STATE OF MICHIGAN

NURSE AIDE TRAINING

CURRICULUM MODEL

Michigan Department of Public Health
Bureau of Health Systems
Division of Federal Support Services
1991

OBRA-6 (2004) Authority: PL 100-203

MICHIGAN NURSE AIDE TRAINING
CURRICULUM MODEL, 1991

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INTRODUCTION

BACKGROUND

In 1987, Congress included in the Omnibus Budget Reconciliation Act (OBRA), legislation affecting the operation of nursing homes. A section of the legislation stated that all nurse aides employed in nursing facilities after October 1, 1990, must successfully complete a minimum 75 hours of training which includes classroom, laboratory, and clinical instruction in a State approved nurse aide training program. Nurse aides in nursing homes must also pass a competency evaluation test (written and clinical) and have their names entered on a State registry.

The State Department of Public Health is the agency in Michigan which is charged with implementation of this legislation. As part of this implementation, the Michigan Nurse Aide Training Curriculum, 1989, was developed to be used by instructors in the Nurse Aide Training Program in a variety of ways: as a curriculum guide to be used in the development of a 75 hour training program, as a complete curriculum to be used as is, or adapted to fit specific facilities or training programs.

REVISED CURRICULUM MODEL

The Michigan Nurse Aide Training Curriculum, 1989, has now been revised to build on the strengths of the model, to expand content in selected areas such as Dementia/Cognitive Impairment, and to include new content such as Creating an Environment for Restraint Elimination, Reduction, and Appropriate Use. The revised curriculum is in a lesson plan format which identifies learner objectives, content, teaching methodologies, and evaluation. Time allocation for class, lab, and clinical and a sample program schedule are also included.

The Michigan Nurse Aide Training Curriculum, 1991, is a 75 hour curriculum which will assist an instructor to develop a classroom management system which meets Federal Requirements for a Nurse Aide Training Program. This 75 hour program provides an overview of many areas and is not meant to be inclusive of all information needed by a nurse aide working in a long term care facility. Many topics, such as cognitive impairment/dementia, will need to be given more emphasis and more in depth instruction via staff development programs once the training is completed. The curriculum provides a framework for ensuring minimal competency of nurse aides; when the training program is complete, nurse aides should continue to have support and instruction on an ongoing basis.

Performance guides and achievement indicators for each clinical skill are included as an appendix in the revised curriculum model. Nursing facilities may use their own procedures, the Michigan Model guide, or other sources for teaching clinical skills. The following information regarding clinical skills will be found in the appendix:

1. Performance guides and achievement indicators for each clinical skill referenced in the Michigan Model, 1991, curriculum.
2. List of clinical skills that should be taught for each unit.
3. Generic components to be included for each clinical skill
4. A Student Achievement Record which contains the task, criteria, date and instructor's signature.

Other additions to the revised curriculum model include references for instructors which are listed in selected units and a suggested Program Calendar.

It is intended by those involved with the development of the Michigan Nurse Aide Training Curriculum, 1991, that it will be used to provide training which meets minimum Federal Requirements and which will prepare nurse aides to provide quality care to residents in long term care facilities.

FEDERAL REQUIREMENTS

The Michigan Nurse Aide Training Curriculum Model, 1991, meets minimum Federal/State Requirements for Nurse Aide Training Programs.

The following are the Federal requirements which are incorporated into the curriculum:

PROGRAM OBJECTIVES

The overall objective of this Nurse Aide Training Program is the provision of quality services to residents in long term care facilities by nurse aides who are able to:

1. Form a relationship, communicate and interact competently on a one-to-one basis with the residents;
2. Demonstrate sensitivity to residents' emotional, social, and mental health needs through skillful, directed interactions;
3. Assist residents in attaining and maintaining functional independence;
4. Exhibit behavior in support and promotion of residents' rights; and
5. Demonstrate observational and documentation skills needed in the assessment of resident's health, physical condition and well-being.

THE ABOVE OBJECTIVES ARE THE PROGRAM OBJECTIVE WHICH REFLECT FEDERAL REQUIREMENTS.

CURRICULUM AND TRAINING REQUIREMENTS

A. The curriculum must include the needs of various populations i.e., persons with dementia, Alzheimer's, mental illness, mental retardation and non-elderly persons with other disabilities that are peculiar to the population of an individual facility.

B. The program must be a minimum of 75 hours of training. At least 16 hours should consist of classroom instruction prior to a trainee's direct involvement with a nursing home resident – and another 16 or more hours should be devoted to skills training. The remaining hours can be used at the discretion of the designers of the training program. (SEE HOUR ALLOCATION, PROGRAM SCHEDULE, AND UNITS 1-7.)

C. Each Nurse Aide Training Program must have behaviorally stated objectives for each unit of instruction. Each objective must state measurable performance criteria which serves as the basis for competency evaluation. (SEE ALL UNITS.)

D. Unit objectives must be reviewed with the trainees at the beginning of each unit so that the trainee knows what is expected of him/her in each part of the training program.

E. The program must use the curriculum objectives for nurse aide training and must adapt the content and skills training application to the facility's specific population.

F. A performance record of major duties and skills must be developed for each nurse aide trainee and consist of the following (minimum requirements):
   1. A listing of duties or skills expected to be learned in the program;
   2. Space to record when the aide performs this duty or skill;
   3. Space to note satisfactory or unsatisfactory performance;
   4. Signature of instructor supervising the performance.

   (SEE STUDENT ACHIEVEMENT RECORD – CLINICAL SKILLS APPENDIX PAGES A-5 THRU A-7)

G. A trainee must be clearly identified during all skills training portions. Identification must be recognizable to residents, family members, visitors and staff.

H. The ratio of instructors to trainees in skills training must ensure that each trainee is provided with effective assistance and supervision.

I. Program hours: Total of 75 hours with 16 hours of minimal instruction prior to the trainee's direct involvement with nursing facility residents. It must include:
   1. Communication and Interpersonal Skills (Units 5)
   2. Infection Control (Unit 6)
   3. Safety/Emergency Procedures (Including the Heimlich Maneuver) (Unit 7)
   4. Promoting Resident's Independence (Unit 3, All Units)
   5. Respecting Resident's Rights (Units 3, All Units)

J. In addition, the program must ensure that each nurse aide at a minimum demonstrates competency in the following areas:
   1. Basic Nursing Skills:
      a. Caring for Residents When Death is Imminent (Unit 18)
      b. Taking and Recording Height and Weight (Unit 12)
      c. Taking and Recording Vital Signs (Unit 12)
      d. Caring for Resident Environment (Unit 9)
      e. Measuring and Recording Fluid and Food Intake (Unit 13)

f. Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor (All units)

2. Personal Care Skills (Unit 8A-*H):
    a. Bathing (Unit 8G)
    b. Grooming (Unit 8A, 8C, 8D, 8F, 8H)
    c. Dressing (Unit 8H)
    d. Toileting (Unit 14)
    e. Assisting with Eating and Hydration (Unit 13)
    f. Proper Feeding Techniques (Unit 13)
    g. Skin Care (Unit 8C, 8D, 8G)
    h. Transfer, Positioning, Turning (Unit 15)

3. Mental Health and Social Services Needs
   Identify the psychological characteristics of nursing home residents with mental retardation and mental illness (Units 16, 17)
    a. Awareness of developmental tasks associated with the aging process (Unit 12)
    b. Modify aide's behavior in response to resident's behavior (Unit 10)
    c. How to respond to resident behavior (Unit 10, All Units)
    d. Allow the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity (Unit 3, All Units)
    e. Using the resident's family as a source of emotional support (Unit 2, 10)

4. Care of Cognitively Impaired Residents
    a. Techniques for addressing the unique needs and behavior of individuals with dementia (Alzheimers and others) (Unit 10)
    b. Communicating with cognitively impaired residents (Unit 10)
    c. Understanding the behavior of cognitively impaired residents (Unit 10)
    d. Appropriate responses to the behavior of cognitively impaired residents (Unit 10)
    e. Methods of reducing the effects of cognitive impairments (Unit 10)

5. Basic Restorative Services:
    a. Training the resident devices in self care according to the resident's abilities (All Units)
    b. Use of assistive devices in ambulation, transferring, eating, dressing (Unit 15)
    c. Maintenance of range of motion (Unit 15)
    d. Turning and positioning in bed and chair (Unit 15)
    e. Bowel and bladder training (Unit 14)
    f. Care and use of prosthetic and orthotic devices (Unit 15)

6. Resident's Rights:
    a. Provide privacy and confidentially (Unit 3, All Units)
    b. Promote residents' right to make personal choices to accommodate their needs (Unit 3, All Units)
    c. Provide assistance in resolving grievances and disputes (Unit 3, All Units)
    d. Provide assistance in getting to and participating in resident and family groups and other activities (Unit 3, All Units)
    e. Maintain care and security of resident's personal possession (Unit 3, All Units)
    f. Promote the resident's right to be free from abuse, mistreatment, neglect, and the need to report any instances of such treatment to appropriate facility staff (Unit 3)
    g. Avoid the need for restraints in accordance with current professional standards.

SOURCES:

1. OBRA Subtitle C, Nursing Home Reform PL 100-203, 1987, National Citizens Coalition for Nursing Home Reform.
2. State Operations Manual, April 1989, Department of Health and Human Services, Health Care Financing Administration.
3. Section 6901. Medicare and Medicaid Technical Corrections Relating to Nursing Home Reform, December 19, 1989.
4. Omnibus Budget Reconciliation Act of 1989 PL 101-239.
5. Omnibus Budget Reconciliation Act of 1990 PL 101-508.
6. Federal Register Vol. 56, No. 187, Thursday, September 26, 1991.

NURSE AIDE TRAINING
Michigan Model Curriculum, 1991
Matrix of Core Curriculum

UNIT	Resident Rights	Restraints	Infection Control	Human Interaction	Safety and Emergency
Long Term Care Facility	X				
Long Term Care Resident	X				
Resident Rights	X				
Member of Health Care Team	X			X	
Human Interaction Skills				X	
Basic Personal Skills	X		X		
Nutrition/Hydration	X			X	X
Elimination	X		X		
Resident Environment	X		X		
Vital Signs			X		
Death and Dying	X			X	
Rehab/Restorative Care	X	X			
Safety/Emergency			X		X
Infection Control			X		
AIDS			X		
Mental Retardation	X			X	
Depression				X	
Restraint	X	X			
Cognitive Impairment	X	X		X	

REQUIREMENTS FOR INSTRUCTORS IN NURSE AIDE TRAINING PROGRAMS:

Instructor requirements for Nurse Aide Training Programs to be approved by the State of Michigan are the following:

PROGRAM COORDINATOR: RN licensed in the State of Michigan; Train-the-Trainer Certificate

The Program Coordinator's responsibilities include:

1. Overall administrative responsibility for the program

PRIMARY INSTRUCTOR: RN licensed in the State of Michigan; Train-the-Trainer Certificate; experience in care of the elderly

The Primary Instructor's responsibilities include the following:

1. Accountable for the entire program; i.e., classroom, laboratory, and clinical.
2. Participates in the planning and evaluation of each segment of the curriculum.
3. Monitors each new instructor in lecture, laboratory, or clinical whenever that person is teaching something new for the first time.
4. On-Site and available during entire clinical teaching time.
5. On-Site and available at least 50% of the classroom and laboratory time.
6. May delegate classroom, laboratory, and/or clinical teaching responsibilities to a Delegated Instructor (another registered nurse or a licensed practical nurse) within the legal scope of practice and assessed capabilities of those individuals.

The Program Coordinator/Primary Instructor may be one or, at the most, two individual (s). If one person is assigned as the Programs Coordinator/Primary Instructor, s/he may delegate teaching responsibilities to Delegated Instructors.

Nursing facilities and non-nursing facilities may have one (1) or more Primary Instructors depending on the type of Nurse Aide Training Program they are conducting.

DELEGATED INSTRUCTOR: RN or LPN licensed in the State of Michigan

Delegated Instructor responsibilities include:

1. Class, laboratory, and/or clinical teaching as delegated by Primary Instructor.
2. Must be supervised by Primary Instructor for at least 50% of class and laboratory time and 100% of clinical teaching time.

GUEST INSTRUCTOR: Individuals with special knowledge such as physical therapists, occupational therapists, speech therapists, physicians, pharmacist, Ombudsman, and dietitians who may assist the Program Coordinator/Primary Instructor or Delegated Instructor in teaching related lecture and laboratory components of a Nurse Aide Training Program.

Guest Instructor responsibilities include:

1. Teaching of content pertaining to area of expertise.

Those responsible for the Nurse Aide Training Program (the Program Coordinator/Primary Instructor/Delegated Instructor) are to verify demonstrated competency in a task/skill and sign the trainee Student Achievement Record.

In a nursing facility based program, the training of nurse aides may be performed under the general supervision of the Director of Nursing for the facility who is prohibited from performing the actual training.

SOURCES:

1. Michigan Public Health Code, Act 368 of 1978 as amended, Article 15 – Occupational Regulations.
2. Omnibus Budget Reconciliation Act of 1987, PL 100-203.
3. Federal Register Vol. 56, No. 187, Thursday, September 26, 1991.

MICHIGAN MODEL CURRICULUM, 1991
HOUR ALLOCATION

*** CORE CURRICULUM**

UNIT	TITLE	CLASS HOURS	LAB HOURS	CLINICAL HOURS	TOTAL HOURS
1	THE LONG TERM CARE FACILITY	1.0			1.0
2	THE LONG TERM CARE RESIDENT	1.0			1.0
3	RESIDENT RIGHTS	2.0			2.0
4	NURSE AIDE AS A MEMBER OF THE HEALTH CARE TEAM	2.0			2.0
5	HUMAN INTERACTION SKILLS	2.0			2.0
6	INFECTION CONTROL	2.0	2.0		4.0
7	SAFETY/EMERGENCY PROCEDURES	2.0	2.0		4.0
				TOTAL (Units 1-7)	16.0
8	BASIC PERSONAL CARE SKILLS				
8A	INTRODUCTION	0.5			0.5
8B	ORAL HYGIENE	1.0	0.5		1.5
8C	SKIN CARE	1.0			1.0
8D	HAND AND FOOT CARE	0.5	0.5		1.0
8E	HAIR CARE AND SHAVING	0.5	1.5		2.0
8F	PERINEAL CARE	0.5	1.0		1.5
8G	BATHING	0.5	1.0		1.5
8H	DRESSING AND APPEARANCE	0.5	0.5		1.0
				6.0 (8B-8H)	
				TOTAL (Unit 8)	16.0

UNIT	TITLE	CLASS HOURS	LAB HOURS	CLINICAL HOURS	TOTAL HOURS
9	CARE OF RESIDENT	0.5	1.5	2.0	4.0
10	CARE OF THE RESIDENT WITH COGNITIVE IMPAIRMENT	3.0		1.0	4.0
11	CREATING AN ENVIRONMENT FOR RESTRAINT ELIMINATION, REDUCTION, APPROPRIATE USE	3.0	0.5	0.5	4.0
12	VITAL SIGNS, HEIGHT, WEIGHT	1.0	1.0	2.0	4.0
13	MEETING NUTRITION/ HYDRATION NEEDS	2.0	1.0	1.0	4.0
14	ELIMINATION	2.0	1.0	1.0	4.0
15	RESTORATIVE/REHABILITATIVE CARE	2.0	2.0	4.0	8.0
16	CARE OF THE RESIDENT WITH MENTAL RETARDATION (DEVELOPMENTAL DISABILITY)	1.0			1.0
17	DEPRESSION	1.0			1.0
18	DEATH, DYING	0.5	0.5		1.0
19	CARE OF THE RESIDENT WITH AIDS	1.0			1.0
20	CLINICAL PRACTICUM - INTEGRATION OF CLINICAL SKILLS			7.0	7.0
TOTAL		34.0	16.5	24.5	75.0

SAMPLE PROGRAM SCHEDULE
75 HOUR NURSE AIDE TRAINING PROGRAM
(Michigan Nursing Aide Training Curriculum, 1991)

Week 1

Day 1	Day 2	Day 3	Day 4	Day 5
A.M.				
Unit 1	Unit 6	Unit 8 A-D	Unit 8 Skills (Clinical)	Unit 8 & 9 (Clinical)
Unit 2				
Unit 3				
P.M.				
Unit 4	Unit 7	Unit 8 E-H	Unit 8 (Clinical)	Unit 10
hours	Core Curriculum	Unit 9		

Week 2

A.M.				
Unit 11	Unit 13	Unit 15	Unit 20 Clinical Practicum Integration of Clinical Skills (4 hours)	Final Test
P.M.				
Unit 12	Unit 14	Unit 16	Integration of Clinical Skills (3 Hours)	
		Unit 17 Unit 18 Unit 19		

GLOSSARY

MICHIGAN NURSE AIDE TRAINING CURRICULUM MODEL, 1991

Abuse Manual:
(The Identification and Reporting of Abuse, A Training Manual for Nursing Home Aides, 1988) A training manual prepared by the Michigan Department of Public Health

Achievement Indicators:
Summary of performance guides – necessary behaviors demonstrated for a student to successfully complete a task.

Behavioral Objective:
Measurable outcomes of student performance which indicate the behavior a student will demonstrate upon successful completion of a learning experience. Behavioral/Learner objectives can be cognitive, affective, or psychomotor.

1. Cognitive – Intellectual learning
2. Affective – Emotional/Social/Value learning
3. Psychomotor – Task/Skill learning

Classroom Instruction:
Instruction provided by Program Coordinator/Primary Instructor, Primary Instructor, Delegated Instructor or guest lecturer in a classroom setting. It includes but is not limited to lecture, discussion, programmed instruction, and media presentations.

Clinical Skills Instruction:
Instruction provided to nurse aide trainees under the direct supervision of Program Coordinator/Primary Instructor, Primary Instructor, or Delegated Instructor in an actual care giving environment in which actual residents are involved.

Clinical Practicum:
An actual clinical experience for nurse aide trainees which occurs during the Nurse Aide Training Program under the supervision of an instructor with the Nurse Aide Training Program. The purpose of the practicum is to evaluate and supervise nurse aide trainees as they integrate and apply the knowledge and skills learned in the class and laboratory.

Competency Based Education:
An education program that utilizes the student's achievement of program specific knowledge, skills, or judgment, at a prespecified level of proficiency, as the criteria for determining successful completion of the instructional program.
Content:
Material/information specific to unit objectives that is presented to the class, via various teaching methods.

Core Curriculum:

A minimum of sixteen hours of instruction which students are taught prior to direct involvement with a resident. The core curriculum must include:

1. communication and interpersonal skills
2. infection control
3. safety and emergency procedures
4. promotion of resident's independence
5. residents' rights.

Criteria:
Standards upon which judgment can be based. The minimum level of performance that is accepted as evidence of achievement of the objectives.

Curriculum:

1. A course of study necessary to achieve leaner objectives. This includes: program objectives/program goals; behavioral/learner objectives for lecture, laboratory, and clinical skills training; teaching methods; evaluation measurements; student policies; program schedule; and faculty schedule.
2. A course of study necessary to achieve learner objectives which includes all of the above except student policies, faculty schedule, and program schedule. Such curricula are independent of a particular Nurse Aide training programs but program may purchase the "package". Examples include ProCare, Medcom, and VideoLink.

Evaluation Measurements:
The methods used to assess whether a student has met the objectives of the program.

1. Criterion referenced
   Learner performance is measured against predetermined criteria built into the objectives. Used for evaluation of skills performance.
2. Norm referenced
   Compares an individuals performance to the performances of others, the class, the group, i.e., percentile, rank. Used with classroom testing.

Grading Criteria:
Standards, cut scores or percentage which determine a students' grade and can also refer to a percentage or grade which determines pass/fail.
Laboratory Instruction:
Instruction provided to nurse aide trainees by Program Coordinator/Primary Instructor, Primary Instructor, or Delegated Instructor in a simulated setting where students practice clinical skills without using actual residents.

Lesson Plan:
A format for structuring unit specific objectives, content, teaching methods, and evaluation criteria into columns to assist the instructor in organizing, planning and presenting instructional material to students.

Michigan Model:
Michigan Nurse Aide Training Curriculum, Revise 1991 (Revised) A task based curriculum model for a 75 hour Nurse Aide Training Program which provides examples of program objectives and behavioral objectives for lecture, laboratory, and clinical skills training.

OBRA Act:
Public Law 100-203 (the Nursing Home Reform Act, Subtitle C of the Omnibus Budget and Reconciliation Act) of December 22, 1987.

Performance Guides:
Series of steps required for the performance of a task arranged in the sequence ordinarily followed.

Program Objective/Federal Program Objective:
Defines, identifies the purpose, desired outcomes, or goal of a program of instructional content. The Federal Program objective of the Nurse Aide Training Program is to provide quality services to residents by nurse aides who are able to:

1. Form a relationship, communicate and interact competently on a one-to-one basis with the residents;
2. Demonstrate sensitivity to residents' emotional, social, and mental health needs through skillful, directed interactions;
3. Assist residents in attaining and maintaining independence;
4. Exhibit behavior in support and promotion of residents' rights; and
5. Demonstrate observational and documenting skills needed in the assessment of resident's health, physical condition and well-being.

Resident Rights:
Michigan Public Health Code Act Number 368 P.A. of 1978 statutory mandate whereby a health facility of agency which provides services directly to patients or residents and which is licensed shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. A Nurse Aide Training Program must contain objectives and content addressing Resident Rights. This includes content from the following:

1. Section 333.20201 of the Michigan Public Health Code
   Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discrimination against patient exercising protected right; exercise of rights by nursing home patient's representative; informing patient or resident of policies; designation of person to exercise rights and responsibilities.
2. Section 333.21771 of the Michigan Public Health Code
   Policy describing abusing, mistreating, or neglecting patient; reports; investigation; retaliation prohibited.
3. OBRA and Social Security Act:

The Omnibus Budget Reconciliation Act of 1987 (PL 100-203), 1989 (PL 101-239), 1990 (PL 101-508) and Sections 1819(f) Medicare and 1919(f) Medicaid of the Social Security Act created federal requirements for Nursing Home Reform. This parallels and expands many Michigan requirements in the content area of Resident Rights.

Student Achievement Record (S.A.R.)/Performance Record:
Ongoing and summative record of major skills to be learned in the program and the trainee's performance of each. The record consists of four (4) components: skill, criteria, date of performance, and signature of instructor.

Syllabus:
A statement of the main course components including the administrative elements and the curriculum components.

Teaching Methods/Methodology:
Selection of instructional methods, materials and approaches to meet the needs and abilities of individual learners in meeting the objectives.

Unit Objective:
Behavioral learner objectives given to the learner at the beginning of each unit of instruction.

GENERAL REFERENCES/RESOURCES

Filmstrips/Audio-Visual Materials

"Experiencing Aphasia"
Nevland, G., Jones, R.
Communications Skills Builder
3830 E. Bellevue
P.O. Box 42050
Tuscon, AZ 85733
(602) 323-7500

"Sounds Heard When Taking Blood Pressure and Pulse"
Smith, Kine & French
1500 Spring Garden Street
Philadelphia, PA 19101

Books

Caldwell, E., Hegner, B. (1991) Assisting in Long-Term Care
Albany, NY, Delmar Publishers.

Caldwell, E., Hegner, B. (1991) Geriatrics, A Study of Maturity
(5th ed.) Albany, NY, Delmar Publishers.

Hogan, J., Sorrention, S. (1988) Mosby's Textbook for Long-Term Care Assistants, St. Louis, The C.V. Mosby Company.

Matteson, M., McConnell, E. (1988) Gerontological Nursing Concepts and Practice
Philadelphia, W.B. Saunders Company.

Menezes, K. (1989) Nursing Assistant Course Guide Big Rapids, Michigan, Matthew Scott Publishers.

Robinson, C., Weigley, E. (1984) Basic Nutrition and Diet therapy (6th ed.) New York, MacMillian Publishing Co.

Sorrentino, S. (1987) Mosby's Textbook for Nursing Assistants St. Louis, The C.V. Mosby Company.

Will, C., Eighmy, J., (1991) Being a Long-Term Care Nursing Assistant, Robert J. Brady Co.

"Diseases"
Intermed Communications, Inc.
132 Welsh Road
Horsham, PA 19044

RESOURCES FOR SELECTED UNITS

Unit 2 – Long-Term Care

1. "Diseases"
   Intermed Communications, Inc.
   132 Welsh Road
   Horsham, PA 19044

2. Duke University Center for Geriatric Education
   Box 3003
   Durham, NC 27710
   (919) 684-2248

Unit 3 – Resident Rights

1. Michigan Public Health Code
   Sections 333.20201 and 333.21771

2. Identification and Reporting of Abuse: A Manual for Nursing Home Aides, Michigan Department of Public Health, 1988

3. Geriatrics, October 1979. "The Need for Personal Space in Institutions for the Elderly," pp. 42-50.

Unit 4 – Health Team Member

1. "The Health Care Worker and Ethics"
   Video Associates
   P.O. Box 1656
   Kalamazoo, Michigan 49081
   A 25 minute video on ethical and legal responsibilities for beginning health care workers. $49.95

Unit 5 – Human Interaction Skills

1. Nursing Life, July/August, 1986. "Communicating Better With the Elderly," pp 25-27

2. Nursing 80, February, 1980. "Pseudo Communication With Patients," pp 105-108

3. Communication Skills Building, "Experiencing Aphasia"
   P.O. Box 42050
   Tuscon, AZ 85733 $24.95 (workbook and 2 audio tapes)

Unit 7 – Safety/Emergency Procedures

1. American Heart Association Publications
   a. Heart Saver Manual
   b. Health Care Providers Manual for BLS

c. Basic Life Support

2. American Red Cross
   a. Adult CPR
   b. Standard First Aid

Unit 8 – Basic Personal Care

1. Gannon, E., Kadezabeh, E. March 1990. "Meticulous Mouth Care," Nursing 80, pp 70-75.

Unit 10 – Cognitive-Impairment

See resources attached to unit

Unit 11 – Restraint Elimination

1. Journal of Gerontological Nursing, 1991, 17 (2) Special issue of restraints.

Unit 12 – Vital Signs

1. American Red Cross
   How to Measure Blood Pressure (manual)

Unit 13 – Meeting Nutrition/Hydration Needs

1. Dairy Council of Michigan, 2163 Jolly Road, Okemos, MI 48864
   (800) 548-8097

2. Robison, G., Weigley, E. (1984) Basic Nutrition and Diet Therapy (6^{th} ed.), New York, MacMilliam Publishing Co.

Unit 15 – Restorative Care

1. Hoeman, S. (1990) Rehabilitation/Restorative Care In the Community, St. Lousi, C.V. Mosby Co.

Unit 19 – AIDS

1. AIDS Hotline – (800) 872-2437

2. Allen, J., April/May 1986. Health Care Worker and the Risk of HIV Transmission, Hastings Center Report.

3. American Health Care Association, 1987. AIDS and the Nursing Home Resident.

4. Michigan Department of Public Health, Office of AIDS Prevention, (517) 335-8468.

Michigan Nurse Aide Training Curriculum Model, 1991

The following people served on the Michigan Nurse Aide Training Curriculum Revision Committee and provided input into the revision of the content, format, and hour allocations.

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SUGGESTED TEACHING METHODS
INFECTION CONTROL

Use of Spray Disinfectant:

1. After the students have entered the room, spray a scented disinfectant from the corner of the room. Instruct the students to raise their hands as they smell the scent. Note which part of the room raises their hands first and the progression it follows.
2. Introduce the Unit. Tell the students that they will learn how infection is spread, how to prevent infection from spreading, and how to wash their hands correctly.
3. Explain concept of how microorganisms are spread.
4. Discuss the following questions:
   A. Could you see the disinfectant in the air?
   B. Did you feel it?
   C. Point out to the group which part of the room the odor was first noted and the progression of the scent. (This information you noted by the way the students raised their hands.)

Conclude that even though you can't see the germs, they are present and capable of spreading infection.

MEDICAL ASEPSIS TEACHING ACTIVITY

The purpose of this activity is to teach and/or reinforce the concept of medical asepsis as it relates to handwashing. The students should have a graphic memory of why it is important to wash their hands frequently and at specific times during their work day.

EQUIPMENT:
1 wash basin filled half full of water.
1 white towel paper or cloth
Finger paints or tempera powder in the colors red, blue, and yellow
1 muffin or donut (must look delicious)

The scenario: select four students from the class, three as patients and one as a fellow nursing assistant. Have them sitting in front of the class. Give each "patient" a diagnosis card to wear or hold. Usually shingles, staph, and hepatitis are good ones to use. Go to the first "patient" and pretend to take a pulse. Then put one of the colors of paint on your hands; they are now contaminated. Go to the second "patient" and take their pulse. Now add another color paint to your hands, and go to "patient" number three. Take their pulse and add the last color paint to your hands. Pick-up the donut/muffin and take it to the student who is playing the part of fellow aide and ask them to go on break and share this treat with you. When they refuse, offer to wash your hands. Then quickly splash your hands in the basin of water and dry them on the towel. Show the class that even though you have "washed" your hands there is still paint/"bacteria" hiding in the skin creases, around nails, and under rings. Show the paint/"bacteria" on the towel and empty the water from the basin and show the paint/"bacteria" residue left in the basin.

WRAP-UP: Have the "patients" discuss how they felt having the nursing assistant care for them with these contaminated hands. Ask if their perceptions of bacteria would change if they were actually able to see that a surface was contaminated. Also bring into the discussion the importance of good handwashing technique. That while the assistant had washed her hands how effective was the washing? Lastly, talk about the other objects that were contaminated such as the sink, towel, and donut.

Care of the Resident with Cognitive Impairment
(Dementia)

This information is excerpted directly from the following sources:

Hall, G.R. and Buckwalter, K.C. (1987) Progressively Lowered Stress Threshold; A Conceptual Model for Adults with Alzheimer's Disease. Archives of Psychiatric Nursing, 1: 399-406.

Rader, J. (1991) Modifying the Environment to Decrease the Use of Restraints. Journal of Gerontological Nursing, 17 (2) 9-13.

Progressively Lowered Stress Threshold (PLST) – A theoretical model for working with cognitively impaired individuals, primarily those with dementia. PLST is a combination of Selye's Stress Model and Lawton's Environment Press Model. As a person's competence decreases, the person will be more affected by the environment and its demands. As the individual's brain function becomes more impaired, the person's ability to process information from the environment and to respond appropriately is diminished. The person is unable to "sort out" and process or interpret stimuli.

Individuals exhibit three major types of behavior:

1. Normative or baseline – calm state which includes the ability to communicate in some way, to be aware of one's surroundings, and to function within one's limits.

2. Anxious behavior – occurs when the person with dementia experiences stress. This behavior occurs when the individual's environment has too many stressors or no opportunities to relax or avoid stimuli. The stress threshold is exceeded which leads to dysfunctional or problem behavior.

3. Dysfunctional behavior – decreased ability to communicate and inability to function appropriately. May be manifested by a catastrophic reaction or sudden change from baseline behavior to an angry outburst, refusal to cooperate, crying, yelling, etc.

   If the stress threshold is repeatedly exceeded, the individual cycles between anxious and dysfunctional behaviors and is unable to return to normative or baseline behavior.

   Using the Progressively Lowered Stress Threshold Model, the goal is to structure the environment and activities in such a way that staff members reduce stressors and make it possible for individuals with dementia to stay within their baseline or normative behavior.

Additional Resources:

Beck, C. and Heacock, P. (1988) Nursing Interventions for Patients with Alzheimer's Disease. Nursing Clinics of North America, 23 (1) 95-124.

Cohen, D. and Eisdorfer, C. (1986) The Loss of Self: A Family Resource for the Care of Alzheimer's Disease and Related Disorders, New York, W.W. Norton.

Cohen, U. and Weisman, G.D. (1991) Holding on to Home, Baltimore, John Hopkins University Press.

Coons, D.H. and Metzelaar, L. (1990) A Manual for Trainers of Direct Service Staff in Special Dementia Units, Ann Arbor, University of Michigan.

Edelson, J.S. and Lyons, W.H. (1985) Institutional Care of the Mentally Impaired Elderly, New York, Van Nostrand Reinhold.

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Maas, M. (1988) Management of Patients with Alzheimer's Disease in Long Term Care Facilities. The Nursing Clinics of North America, 23 (1) 57-64.

Mace, N.L. (1990) Dementia Care: Patient, Family and Community, Baltimore, John Hopkins University Press.

Mace, N.L. and Rabins, P.V., MD (1991) The 36-Hour Day, Baltimore, John Hopkins University Press, Revised Edition.

Robinson, A, Spencer, B., and White, L. (1988) Understanding Difficult Behaviors: Some Practical Suggestions for Coping With Alzheimer's Disease and Related Illness, Ypsilanti, Geriatric Education Center of Michigan, Eastern Michigan University.

Zgola, V. (1987) Doing Things: A Guide to Programs and Organized Activities for Persons with Alzheimer's Disease and Related Disorders, Baltimore, John Hopkins University Press.

Videotapes:

Helping People with Dementia in Activities of Daily Living, 1987, Terra Nova Films, Inc., 9848 S. Winchester Avenue, Chicago, IL 60643.

VALIDATION THERAPY

For information regarding Validation Therapy, the references are available:

Feil, Naomi (1984) Communicating with the Confused Elderly Patient. Geriatrics, 39 (3) page 131.

Feil, Naomi, Validation Therapy (Manual used with film “Looking for Yesterday”. Available for Edward Feil Productions, Cleveland, Ohio.

Restraints

Definition

Source:

State Operations Manual (Revised September 1990)
Transmittal No. 232
P51, F203, F204

Physical Restraint:

Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access.

Psychoactive Drugs (chemical restraints):

Drugs prescribed to control mood, mental status, or behavior.

+CLINCIAL SKILLS

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Introduction

Performance guides and achievement indicators are provided for the skills identified in the Michigan Model Curriculum units. Many facilities have their own procedures for skills, and may use the skills in the Michigan Model Curriculum as supplementary material, allowing the instructor to adapt as necessary. Or, the clinical skills in the Michigan Model Curriculum may be used as written.

The clinical skills will be taught through laboratory and clinical practice. The purpose of the laboratory and clinical practicum is to:

1. Promote safe resident care by ensuring practice of skills.

2. Promote learning of skills through repetition.

3. Simulate experiences to ease the transition from theory to actual clinical situations.

The Student Achievement Record (SAR) is signed as evidence that the student is competent and ready to perform the skill on the job. If it is the instructor's opinion that the skill needs more practice, additional time to practice the skill should be provided before the SAR is signed as a "pass".

Clinical Skills To Be Taught
For Each Unit
Michigan Nurse Aide Training Curriculum Model, 1991

Unit	Title	Clinical Skills
1	Long Term Care Facility	None
2	Long Term Care Resident	None
3	Resident Rights	None
4	Member of Health Care Team	None
5	Human Interaction Skills	None
6	Infection Control	Handwashing Isolation Techniques Universal Precautions
7	Safety/Emergency Procedures	Assisting the Resident who falls Assisting the Resident having a seizure Assisting an unconscious Resident Assisting the Resident who is burned Assisting the Resident who is bleeding Heimlich Maneuver Fire Safety Procedures
8	Basic Personal Care Skills	Oral Hygiene/Teeth – Edentate Oral Hygiene/Dentures Oral Hygiene/Unconscious Resident Oral Hygiene/Conscious Resident – Total Assistance Fingernails/Cleaning and Trimming Foot Care Hair Care – Shampoo Hair Care – Styling (Comb and Brush) Shaving (Blade Razor) Perineal Care – Male Perineal Care – Female

		Bathing/Tub – Shower Bathing/Bed
		Skin Care/Inspection
		Dressing
9	Care of Resident Environment	Bed Operation Making an unoccupied bed Making an occupied bed
10	Care of Resident with Cognitive Impairment	None
11	Creating an environment for Restraint Elimination, Reduction, Appropriate Use	Application/removal physical restraints
12	Vital Signs, Height, Weight	Take/record temperature: oral – axillary – rectal
		Take/record Pulse
		Take/record Respirations
		Take/record Blood Pressure
		Take/record height and weight
13	Nutrition/Hydration	Feed Resident
		Measure/record intake and output
14	Elimination	Assist with bedpan/urinal Assist with bedside commode/toilet
		Catheter Care
		Urine/Stool specimen collection
15	Rehabilitative/Restorative Care	Proper body mechanics Ambulate Resident Transfer techniques Position Resident in bed Turn Resident in bed Mechanical lift

		Range of motion Walker assistance Cane assistance Wheelchair assistance
16	Care of the Resident with Mental Retardation	None
17	Depression	None
18	Death and Dying	Postmortem Care
19	The Resident with Acquired Immune Deficiency Syndrome (AIDS)	None
20	Clinical Practicum	Integration of Clinical Skills

ESSENTIAL COMPONENTS FOR CLINICAL SKILLS

All procedures should BEGIN with the following actions:

1. Wash your hands
2. Assemble equipment needed
3. Go to the resident's room, knock, and pause before entering
4. Introduce yourself and verify the resident's identity
5. If appropriate, ask visitors to leave and inform them where they can wait
6. Provide privacy
7. Explain what will happen and answer questions
8. Allow resident to assist in procedure as much as possible
9. Raise bed or table to comfortable working height

All procedures should be COMPLETED with the following actions:

1. Position resident comfortably
2. Leave signal cord, telephone, and fresh water close at hand
3. Return bed or table to lowest position
4. Perform general safety check of resident and environment
5. Wash your hands
6. Report completion of task
7. Let visitors know they may re-enter the resident's room
8. Document action and your observations

APPROPRIATE PHYSICAL AND VERBAL CONTACT SHOULD BE USED THROUGHOUT ALL PROCEDURES

STUDENT ACHIEVEMENT RECORD

Michigan Nurse Aide Training Curriculum Model, 1991

Student:_____

Social Security #:_____

Instructions:
Mark each student's level of competence according to the following guide:

S = Satisfactory (Student performs skill without assistance according to criteria)

U = Unsatisfactory (Student does not perform skill according to criteria/needs assistance)

	Task	Criteria S	Criteria U	Date	Instructor's Signature
1.	Handwashing				
2.	Isolation Technique				
3.	Universal Precautions				
4.	Assisting the resident who falls				
5.	Assist the resident having a seizure				
6.	Assist an unconscious resident				
7.	Assist the resident who is burned				
8.	Assist the resident who is bleeding				
9.	Heimlich Maneuver				
10.	Fire Safety Procedures (Facility Policy)				
11.	Oral hygiene/teeth - Edentate				

	Task	S	U	Date	Instructor's Signature
12.	Oral hygiene – denture care				
13.	Oral hygiene/unconscious resident				
14.	Oral hygiene/conscious resident – total assistance				
15.	Fingernails/cleaning and trimming				
16.	Foot Care				
17.	Hair Care - Shampoo				
18.	Hair Care – Styling (Comb and Brush)				
19.	Shaving (Blade Razor)				
20.	Perineal Care - Male				
21.	Perineal Care - Female				
22.	Bathing/tub - shower				
23.	Bathing - bed				
24.	Skin care/inspection				
25.	Dressing				
26.	Bed operation				
27.	Making an occupied bed				
28.	Making an unoccupied bed				
29.	Application/removal Physical Restraints				
30.	Take/record temperature: oral – axillary – rectal				

	Task	S	U	Date	Instructor's Signature
31.	Take/record pulse				
32.	Take/record respirations				
33.	Take/record blood pressure				
34.	Take/record height and weight				
35.	Feed resident				
36.	Measure/record intake and output				
37.	Assist with bedpan/urinal				
38.	Assist with bedside commode/toilet				
39.	Catheter Care				
40.	Urine/stool specimen collection				
41.	Proper body mechanics				
42.	Ambulate resident				
43.	Transfer techniques (bed to wheelchair)				
44.	Position resident in bed				
45.	Turn resident in bed				
46.	Mechanical lift				
47.	Range of Motion				
48.	Walker assistance				
49.	Cane assistance				

Task	S	U	Date	Instructor's Signature
50. Wheelchair assistance				
51. Postmortem care				

Comments:

Instructor Signature Date

TASK:
Handwashing

STANDARD:
Hands, wrist and fingernails must be dry and free of pathogenic microorganisms.

TOOLS AND EQUIPMENT:

Dispenser – soap	Paper towels	Water
Liquid soap/bar soap	Sink	
Orange stick or nail brush	Wastepaper basket	

PERFORMANCE GUIDE:

1. Approach sink

2. Turn on water

3. Adjust water temperature to warm

4. Wet wrist and hands thoroughly with water holding hands downward

5. Apply soap; rinse bar soap before using

6. Lather hands well by rubbing palms together

7. Wash hands using friction and rotating motion for a minimum of 1 minute
   a. Wash palms and back of hands
   b. Wash fingers in rotary motion, wash between fingers
   c. Wash wrists in circular motion

8. Clean fingernails with orange stick or nail brush; if fingernails are very short, rub on opposite palm

9. Rinse wrists and hands well

10. Pat wrists and hands dry

11. Turn water off using a DRY paper towel

12. Discard all paper towels into wastepaper basket

Student Name_____

TASK:
Handwashing

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Assembled equipment		
2. Performed handwashing procedure in Prescribed manner		
3. Left handwashing area neat and clean		

CRITERIA:

Competence in the task will be recognized when hands are cleaned according to the procedure of the training program and the achievement indicators listed.

TASK:
Isolation Techniques

STANDARD:
Techniques will be used to prevent the spread of microorganisms among patients, personnel, and visitors.

TOOLS AND EQUIPMENT:

Face masks	Gowns	Gloves	Linen
Color coded isolation signs	Plastic bags	Tags	

PERFORMANCE GUIDE:

PUTTING ON AND TAKING OFF A DISPOSABLE PAPER FACE MASK

1. Wash your hands
2. Adjust over your nose and mouth. Be careful not to touch your face with your hands
3. First tie top strings of the mask behind your head. Then tie the bottom strings securely.
4. Replace mask if it becomes moist during procedure.
5. When ready to dispose of mask, wash your hands first.
6. Untie bottom strings first.
7. Untie top strings. Remove the mask by holding the top strings. Discard in appropriate infectious waste receptacle, located inside the patient's room.
8. Wash your hands.

PUTTING ON A COVER GOWN

1. Remove your wristwatch and place on the clean side of an open paper towel.
2. Wash your hands
3. Put on cover gown by slipping arms into sleeves.
4. Slip fingers under inside neckband and grasp ties in the back. Secure neckband with a simple bow, or fasten Velcro strips.

5. Reach behind and overlap the edges of the gown so that your uniform is completely covered. Secure waist ties with a simple bow, or fasten Velcro strips.

6. NOTE: The watch will be carried with into the isolation unit. It will remain on the paper towel so it can be referred to without being touched.

PUTTING ON GLOVES

Put on clean gloves. If wearing gown, be sure cuffs of gloves overlap gown.

REMOVING CONTAMINATED COVER GOWN, GLOVES, AND MASK

1. Remove gloves. Use preferred hand to pull off opposite glove without touching inside of opposite glove. Discard glove. Remove second glove by reaching inside the glove with ungloved hand and pull glove off. Discard glove.

2. Undo waist ties of gown.

3. Holding a clean paper towel, turn faucets on. Discard towel.

4. Wash your hands. Dry with paper towel.

5. Using a dry paper towel, turn off faucets.

6. Undo mask (bottom ties first, then top ties). Holding by ties only, dispose of mask.

7. Undo the neck ties and loosen gown at shoulders.

8. Slip fingers of the right hand inside the left cuff without touching the outside of the gown. Pull gown down over the left hand.

9. With the gown-covered left hand, pull the gown down over the right hand.

10. Fold gown with contaminated side inward. Roll and dispose of in appropriate receptacle.

11. Wash hands using the technique described in steps 3-5.

12. Remove watch from clean side of paper towel. Holding clean side of paper towel, dispose of towel in wastepaper receptacle.

DOUBLE-BAGGING TO TRANSFER CONTAMINATED ARTICLES TO THE OUTSIDE OF THE ISOLATION UNIT

1. Two people assist in the procedure. One person is inside the unit, and a "clean" person is outside the unit.

2. Inside the unit, place the article into an isolation bag (usually a color-coded plastic bag).

3. Secure with a tie.

4. The person on the outside of the isolation unit holds the cuffed plastic bag over hands to receive bagged item.

5. The clean person secures top of plastic bag tightly.

6. Clean person removes double-bagged item. Disposable items are routed as infectious waste.

CARING FOR LINEN IN THE ISOLATION UNIT

1. Bring clean linen to the unit as needed.

2. Handle soiled linen as little as possible.

3. Place soiled linen in leakproof laundry bag in unit.

4. The bag should be labeled or identified by color code.

5. Secure the bag and route linen according to facility policy. Many facilities use a plastic-type outer bag that dissolves in the washer, freeing the linen. With this type of bag, personnel do not have to handle the linen after it leaves the isolation unit.

Student Name_____

TASK:

Isolation Techniques

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Washed hands at appropriate times		
2. Identified resident		
3. Explained procedure		
4. Demonstrated basic isolation techniques		
5. Handled contaminated articles applying Infection control principles		
6. Removed gloves and gown appropriately		
7. Communicated with isolated resident to decrease feelings of loneliness		
8. Used appropriate physical and verbal contact with resident		

CRITERIA:

Competency with be recognized when isolation techniques are followed to prevent the spread of microorganisms.

TASK:
Universal Precautions

STANDARD:
The Center for Disease Control recommendations for preventing transmission of pathogens such as the human immunodeficiency virus (HIV) and Hepatitis B virus (HBV), will be used to minimize the risk of exposure to blood and body fluids. Universal Precautions are to be carried out by all health care workers.

TOOLS AND EQUIPMENT:

Gloves	Gown	Goggles
Plastic aprons	Sink	Water
Paper Towels	Wastepaper Basket	

PERFORMANCE GUIDE:

1. Wear gloves touching blood, body fluids, mucus membranes, non-intact skin. (See procedure for putting on and removing gloves).

2. Wash hands immediately after removing gloves and immediately after contamination with blood or body fluids.

3. Wear gown or apron for procedures likely to generate splashes of blood or other body fluids.

4. Wear a mask and protective eyewear for procedures likely to generate splashes of blood or other body fluids.

5. Handle waste and soiled linen in accordance with facility policy.

6. Handle sharp instruments with special precautions, dispose of properly.

Universal blood/body fluid precautions chart (Courtesy of BREVIS Corp.)

Student Name_____

TASK:
Universal Precautions

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Identified resident		
2. Demonstrated Universal Precautions according to procedure		
3. Explained procedure		
4. Recognized when Universal Precautions are needed		
5. Considered all body fluids as potential risks for HIV/HBV		
6. Took precautions when working with sharp instruments to prevent injuries		
7. Used appropriate physical and verbal contact with resident		

CRITERIA:

Competency will be recognized when Universal Precautions are used to minimize risks of exposure to HIV and HBV.

TASK:
Assisting the Resident who falls

STANDARD:
Resident must be lowered to the floor without injury to resident or self and an appropriate report made.

TOOLS AND EQUIPMENT:
Gait belt (if facility policy)

Accident/Incident report form

PERFORMANCE GUIDE:

1. Stand with your feet apart. Keep your back straight.

2. Bring the resident close to your body as quickly as possible. Use the gait belt on the resident if one is worn. If the resident is not wearing a gait belt, wrap your arms around the resident's waist or hold the resident under his or her arms.

3. Move your leg so the resident's buttocks rest on your leg. Move the leg nearest to the resident.

4. Lower the resident to the floor. Allow him or her to slide down your leg to the floor. Bend at your hips and knees as you do this.

5. Call a nurse to check the resident.

6. After the nurse has checked the resident, help the nurse return the resident to bed. Get other co-workers to help if necessary.

7. Report the following to the nurse:
   a. What time the resident got up
   b. How far the resident walked
   c. How the resident tolerated the activity prior to the fall
   d. Any resident complaints prior to the fall
   e. The amount of assistance needed by the resident while walking
   f. Sign the appropriate Accident/Incident report form

Student Name_____

TASK:
Assisting the Resident who falls

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Used proper body mechanics		
2. Resident kept close to student's body		
3. Resident gently lowered to floor in prescribed Manner		
4. Student verbalized appropriate information to Report to the nurse		
5. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident (actor) is lowered to the floor according to the procedure of the training program and the achievement indicators listed.

TASK:
Assisting the Resident having a seizure

STANDARD:
Injury will be prevented and an airway will be maintained. The resident should not be left alone.

TOOLS AND EQUIPMENT:
Pillow

PERFORMANCE GUIDE:

1. Ring/call for assistance
2. Do not leave the resident
3. Assist the resident to lie down if possible
4. Do not attempt to restrain the resident
5. Move objects that might injure the resident
6. Loosen clothing, particularly around the neck
7. Place pillow or soft padding under the resident's head if available
8. Turn resident's head to one side to allow for saliva/vomitus drainage
9. Observe the resident during and following the seizure
10. Report your observations to the nurse
11. Wash hands

Student Name_____

TASK:
Assisting the Resident having a seizure

ACHIEVEMENT INDICATORS: The Trainee	Yes	No
1. Summoned assistance		
2. Stayed with the resident		
3. Provided for safety		
4. Reported observations		
5. Washed hands		
6. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident having a seizure is protected from injury and an open airway is maintained.

TASK:
Assisting an unconscious Resident

STANDARD:
Appropriate assistance will be given to the unconscious resident

TOOLS AND EQUIPMENT:
None

PERFORMANCE GUIDE:

1. Call for assistance from nurse
2. Check for breathing
3. Check for pulse
4. Begin CPR if trained and per facility policy
5. Observe for specific signs and symptoms
6. Assist the nurse in anyway possible
7. Wash hands

Student Name_____

TASK:
Assisting an unconscious Resident

ACHIEVEMENT INDICATORS: The Trainee	Yes	No
1. Obtained assistance		
2. Checked breathing and pulse. Provide CPR if warranted and per facility procedure		
3. Provided assistance to nurse		
4. Reported observations about incident		
5. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when appropriate assistance is given to an unconscious resident.

TASK:
Assisting the Resident who is burned

STANDARD:
Provide first aid for a burn

TOOLS AND EQUIPMENT:
Cool water Accident/incident report forms

Basin or washcloth

PERFORMANCE GUIDE:

1. Remove the source of heat
2. Call for assistance
3. When possible, assess the degree of the burn
4. Cool area with cool water until pain subsides
5. Assist as necessary when help arrives
6. Wash hands
7. Report information/sign report

Student Name_____

TASK:
Assisting the Resident who is burned

ACHIEVEMENT INDICATORS: The Trainee	Yes	No
1. Followed principles of cleanliness and Universal Precautions		
2. Communicated with resident to reassure		
3. Obtained assistance		
4. Followed steps to provide burn first aid		
5. Reported observations about incident		
6. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident is provided with first aid assistance for a burn.

TASK:
Assisting the Resident who is bleeding

STANDARD:
First aid will be provided to control bleeding and prevent infection.

TOOLS AND EQUIPMENT:
Gloves Accident/Incident report form

Gauze or clean cloth

PERFORMANCE GUIDE:

1. Ring/call for assistance
2. Put on gloves
3. Apply pressure directly to the wound with your hand over a gauze, tissue or cloths for 5-10 minutes
4. Elevate injured part above the level of the resident's heart. Continue using direct pressure
5. Do not remove the dressing. This will disturb the cloths already formed.
6. Assist as necessary when help arrives
7. Dispose of soiled dressing
8. Clean work area
9. Remove gloves
10. Wash hands

Student Name_____

TASK:
Assisting the Resident who is bleeding

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Followed steps to stop bleeding		
2. Followed principles of cleanliness/Universal Precautions		
3. Communicated with resident to reassure		
4. Obtained assistance		
5. Reported observations about incident		
6. Washed hands		
7. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident is provided with first aid assistance for bleeding.

TASK:
Heimlich Maneuver

STANDARD:
Procedure performed using all steps in appropriate sequence and with appropriate technique.

TOOLS:
None

PERFORMANCE GUIDE:

Note: During the practice of these skills, do not actually perform thrusts on your partner. Rather, simulate these skills on your partner.

1. Assessment
   a. Determine airway obstruction.
      Ask, “Are you choking?”
      Determine if victim can speak, cough, or breathe

   b. Situation: Victim cannot speak, cough, or breathe
      Call for help
      Shout “Help!”

2. Heimlich maneuver. Perform abdominal thrusts
   a. Stand behind the victim
   b. Wrap arms around victim’s waist
   c. Make a fist with your one hand and place thumb side of your fist against victim’s abdomen in the midline slightly above the navel and well below the tip of the xiphoid
   d. Grasp fist with your other hand
   e. Press into the victim’s abdomen with quick upward thrusts
   f. Each thrust should be distinct and delivered with the intent of relieving the airway obstruction
   g. Repeat thrusts until object is expelled or the victim becomes unconscious
   h. No pressure should be exerted against the victim’s rib cage with the rescuer’s forearms.

3. Report your observations to the nurse.

Student Name_____

TASK:
Heimlich Maneuver

ACHIEVEMENT INDICATORS: The Trainee: Yes No

1. Performed assessment in the appropriate manner
2. Performed abdominal thrust using appropriate technique
3. Used appropriate physical and verbal contact

CRITERIA:

Competence in task will be recognized when Heimlich Maneuver is performed according to the procedure of the training program and achievement indicators listed.

TASK:
Oral Hygiene/Resident with teeth or edentate (Resident without teeth/Dentures)

STANDARD:
Resident's teeth must be clean and flossed resulting in no food particles in mouth or between teeth. The oral cavity must be clean and without residual food particles in mouth. Dentures must be clean and in place in resident's mouth. Procedure must be recorded on resident's chart.

TOOLS AND EQUIPMENT:

Dental floss	Resident's chart
Denture cup	Toothbrush
Emesis basin	Toothpaste or dentifrice
Mouthwash	Towels
Water or antiseptic solution	Dentures
Gloves	

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Provide privacy
4. Wash hands
5. Assemble equipment at bedside
6. Position resident appropriately for level of consciousness
7. Place towel across chest of resident and emesis basin under resident's chin
8. Allow resident to brush teeth/clean oral cavity if condition permits
    a. For incapacitated resident:
        (1) Put on gloves
        (2) Moisten brush
        (3) Apply toothpaste or dentifrice to brush
        (4) Move brush back and forth in short vibrating strokes cleaning two or three teeth at a time

(5) Brush entire surface of mouth if edentate surface of tongue and gums may be brushed with soft bristle toothbrush
(6) Instruct resident to rinse mouth with clean water

9. Allow resident to floss teeth if condition permits
   a. For incapacitated resident: *
      (1) Put on gloves
      (2) Remove 18 inch strand of floss
      (3) Guide floss between teeth using up and down motion scraping teeth
      (4) Discard soiled floss frequently
      (5) Instruct resident to rinse mouth

10. Leave resident comfortable with call bell within reach

11. Clean area

12. Remove gloves

13. Wash hands

14. Chart care

- See CDC's Universal Precautions

Student Name_____

TASK:
Give Oral Hygiene/Teeth or Edentate

ACHIEVEMENT INDICATORS: The Trainee	Yes	No
1. Introduce self		
2. Washed hands before and after procedure		
3. Provide privacy		
4. Assembled supplies and equipment		
5. Identified resident		
6. Explained procedure for oral hygiene		
7. Put on and removed gloves at appropriate time		
8. Positioned resident according to condition		
9. Assisted resident with oral hygiene according to the needs/condition of the resident in a prescribed manner		
10. Cleaned and replaced equipment		
11. Recorded/reported procedure and observations		
12. Left call bell within reach		
13. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident is given oral hygiene according to the procedure of the training program and the achievement indicators listed.

TASK:
Oral Hygiene/Denture Care

STANDARD:
Dentures must be clean and in place in resident's mouth. Procedure must be recorded on resident's chart.

TOOLS AND EQUIPMENT:

Dentures	Denture cup	Towels
Toothpaste or dentifrice	Toothbrush	Emesis basin
Resident's chart	Gloves	Water

PERFORMANCE GUIDE:

1. Wash hands
2. Raise bed to working height, lower side rails
3. Provide privacy
4. * Remove upper dentures first (slide finger along gum line and pull down to break seal or grasp front teeth with thumb and index finger. Move dentures up and down to break vacuum) and place in emesis basin.
5. Remove lower dentures (turn resident slightly to prevent discomfort) and place in emesis basin (Raises side rails)
6. Take dentures to sink. Cover bottom of sink with towels and fill sink with cool water.
7. Clean dentures thoroughly with toothbrush and paste over sink full of water.
8. Rinse in cool water and place on paper towel or in emesis basin.
9. Rinse out emesis basin. Place dentures in emesis basin and take back to resident.
10. Perform mouth care (rinse resident's mouth and inspect)
11. Replace dentures (bottom first)
12. Wash hands

- See CDC's Universal Precautions

Student Name_____

TASK:

Oral Hygiene/Dentures

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Provided privacy		
4. Assembled supplies and equipment		
5. Identified resident		
6. Explained procedure for cleaning and cleaning dentures		
7. Put on and removed gloves at appropriate time		
8. Removed and cleaned dentures (used Universal Precautions as appropriate)		
9. Assisted resident with oral hygiene according to the needs/condition of the resident in a prescribed manner		
10. Cleaned and replaced equipment		
11. Recorded/reported procedure and observations		
12. Left call bell within reach		
13. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident is given oral hygiene according to the procedure of the training program and the achievement indicators listed.

TASK:
Oral Hygiene/Unconscious Resident

STANDARD:
Resident's teeth must be clean and flossed with no food particles in mouth between the teeth. Procedure must be recorded on resident's chart.

TOOLS AND EQUIPMENT:

Emesis basin	Toothpaste	Toothbrush
Resident's chart	Towels	Gloves
Resident's chart	Suction machine	Mouth swabs
Padded tongue blades	Lubricant	Flashlight

PERFORMANCE GUIDE:

1. Wash hands
2. Identify resident
3. Explain procedure
4. Provide privacy
5. Raise bed to working height
6. Gather equipment and place in convenient place: toothbrush, emesis basin, mouth swabs, lubricant if needed, functioning suction machine, padded tongue blades
7. Lower HOB, remove pillow, and turn patient head/body to side facing nurse
8. Place towel and emesis basin under chin
9. * Wet toothbrush, toothette or padded tongue blade with water, half strength H_2O_2 or other appropriate material
10. Brush all surfaces of teeth using massaging motion at gumline/cleans entire mouth with swabs
11. Brush tongue
12. Wipe mouth prn

13. Floss teeth (q 24h)
14. Check buccal cavity using flashlight and tongue blade (once every 24 hours)
15. Lubricate lips if dry and cracked
16. Clean and replace equipment
17. Washes hands
18. Reports any pertinent observations

- See CDC's Universal Precautions

Student Name_____

TASK:

Oral hygiene/Unconscious Resident

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Provided privacy		
4. Assembled supplies and equipment		
5. Identified resident		
6. Explained procedure for oral hygiene		
7. Put on and removed gloves at appropriate time (used Universal Precautions as appropriate)		
8. Assisted resident with oral hygiene according to the needs/condition of the resident in a prescribed manner		
9. Cleaned and replaced equipment		
10. Recorded/reported procedure and observations		
11. Left call bell within reach		
12. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident is given oral hygiene according to the procedure of the training program and the achievement indicators listed.

TASK:
Oral Hygiene/Conscious Resident – Total Assistance

STANDARD:
Resident's teeth must be clean and flossed with no food particles in mouth or between the teeth. Procedure must be recorded on resident's chart.

TOOLS AND EQUIPMENT:

Dental Floss	Emesis basin	Flashlight
Gloves	Mouthwash	Water
Toothbrush	Toothpaste	Lubricant
Resident's chart	Tongue blade	

PERFORMANCE GUIDE:

1. Washes hands
2. Identifies resident
3. Explains procedure
4. Provides privacy
5. Raises HOB to Folwer's position if allowed, otherwise, turns resident's head to face nurse
6. * Places equipment in front of resident: emesis basin, water cup, toothbrush and toothpaste if desired, tissues, lubricant if needed
7. Cover chest with a towel
8. Wets toothbrush and spreads toothpaste if used
9. Places emesis basin under chin
10. * Brushes all surfaces of teeth using massaging motion at gumline
11. Allows resident to rinse mouth prn
12. Brushes tongue
13. Offers mouthwash

14. * Floss teeth (q 24h)

15. Wipes mouth when completed

16. Checks buccal cavity using flashlight and tongue blade (1q 24h)

17. Lubricates lips if dry and cracked

18. Cleans and replaces equipment

19. Washes hands

20. Reports any pertinent observations

Note: Reinforce that a resident should do as much of his or her own mouth care as possible

- See CDC's Universal Precautions

Student Name_____

TASK:

Oral Hygiene/Conscious Resident – Total Assistance

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Provided privacy		
4. Assembled supplies and equipment		
5. Identified resident		
6. Explained procedure for oral hygiene		
7. Put of and removed gloves at appropriate times (used Universal Precautions as appropriate)		
8. Positioned resident according to condition		
9. Provided resident with oral hygiene according to the needs/condition of the resident in a prescribed manner		
10. Cleaned and replaced equipment		
11. Recorded/reported procedure and observations		
12. Left call bell within reach		
13. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident is given oral hygiene according to the procedure of the training program and the achievement indicators listed.

TASK:
Fingernails/Cleaning and Trimming

STANDARD:
Resident's fingernails must be cleaned without damaging the skin or nails, and trimmed without rough edges or breaking of skin. Procedure must be recorded on resident's chart

TOOLS AND EQUIPMENT:

Basin	Nail clippers	Soap
Orange stick	Protection for bed linens	Resident's chart
Emery board	Towel, washcloth	Cleaning supplies

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Wash hands
4. Assemble equipment and supplies
5. Protect linens
6. Soak hands
7. Dry hands
8. Clean under fingernails with an orange stick. Clip nails carefully; straight across
9. Gently push cuticle back with washcloth
10. Shape and smooth rough edges with emery board
11. Assure resident's comfort/call bell with reach
12. Clean area
13. Clean and return equipment to storage
14. Wash hands
15. Record nursing care

Student Name_____

TASK:

Fingernails/cleaning and trimming

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Assembled equipment and supplies		
4. Identified resident		
5. Explained procedure for cleaning and trimming fingernails		
6. Cleaned and trimmed nails in prescribed manner		
7. Positioned resident and equipment to assure comfort and safety of resident/call bell within reach		
8. Cleaned and replaced equipment		
9. Recorded/reported procedure and any pertinent observations		
10. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the fingernails of the resident are cleaned and trimmed according to the procedure of the training program and the achievement indicators listed.

TASK:
Foot Care

STANDARD:
The skin on the resident's feet will be clean, dry, intact and free of any signs of redness or irritation. Procedure must be recorded on the resident's chart.

TOOLS AND EQUIPMENT:

Basin	Soap	Towels	Lotion	Washcloth
Orange stick	Disposable underpad	Resident's chart	Cleaning supplies	

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Wash hands
4. Assemble equipment
5. Pull the curtain around bed to provide privacy
6. Assist resident to sit in chair
7. Place basin of warm (109-111 degrees) water on disposable pad on the floor
8. Soak feet for 10-20 minutes
9. Clean under toenails with orange stick
10. Scrub calloused areas on feet with washcloth
11. Remove feet basin basin, dry thoroughly
12. Apply lotion. Inspect toenails and skin on feet
13. Assure resident's safety and comfort
14. Clean area
15. Wash hands
16. Report and record observations

Student Name_____

TASK:

Foot Care

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Assembled equipment and supplies		
4. Identified resident		
5. Provided privacy		
6. Explained procedure for foot care		
7. Provided foot care in the prescribed manner		
8. Positioned resident and equipment to assure comfort and safety of resident/call bell within reach		
9. Recorded and reported procedure and any pertinent observations		

CRITERIA:

Competence in the task will be recognized when foot care is provided according to the procedure of the training program and the achievement indicators listed.

TASK:
Hair Care – Shampoo

STANDARD:
Resident's hair must be clean. Bed linens and resident's bedclothes must be kept dry. Procedure must be recorded on resident's chart.

TOOLS AND EQUIPMENT:

Bath blanket	Resident's chart	Bath thermometer	Safety pin
Blow dryer	Shampoo	Chair	Towels
Small pitcher of cool water		Large pitcher of warm water	
Pail	Waterproof sheets		

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identify and explain procedure
3. Wash hands
4. Assemble equipment
5. Adjust bed to lowest head position
6. Position chair next to bed with waterproof sheet over chair
7. Close windows and doors/provide privacy
8. Remove pillow from resident's head
9. Position resident to side of bed
10. Fold back bed linens to resident's waist
11. Cover patient with bath blanket
12. Position pillow under resident's shoulders covering pillow with waterproof sheet
13. Pin bath towel around resident's neck
14. Roll waterproof sheet so it channels into pail

15. Comb and brush resident's hair to scalp

16. Instruct resident to close his/her eyes and hold towel or washcloth over eyes

17. Pour warm water over hair

18. Pour shampoo onto scalp and hair

19. Work up lather with both hands, start at hairline and work toward back of head. Massage scalp with fingertips

20. Rinse hair with warm water

21. Continue procedure until hair squeaks when stroked

22. Squeeze excess water from hair

23. Remove waterproof sheet from pillow

24. Rub resident's hair with towel

25. Change bed linens is necessary

26. Comb and brush resident's hair

27. Dry hair with blow dryer if needed

Note: leave dry towel under resident's head until hair is completely dry

28. Assure resident comfort/call bell within reach

29. Clean and return equipment to storage

30. Clean area

31. Wash hands

32. Record/Report condition of hair and scalp and resident's tolerance at procedure

Student Name_____

TASK:

Hair Care – Shampoo

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduce self		
2. Washed hands before and after procedure		
3. Assembled equipment and supplies		
4. Provided privacy		
5. Provided for protection of bed with plastic/rubber sheets		
6. Provided receptacle on floor for water to flow into		
7. Prevented drafts in room		
8. Protected eyes and ears of resident		
9. Shampooed hair per procedure		
10. Rinsed with warm water		
11. Dried hair		
12. Combed/brushed hair		
13. Returned/disposed of materials		
14. Provided for resident's comfort and safety/call bell within reach		
15. Reported/recorded procedure and any pertinent observations		
16. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when each achievement indicators has been demonstrated to the satisfaction of the evaluator.

TASK:
Hair Care – Styling (Comb and Brush)

STANDARD:
Resident's hair must be parted and arranged to resident's request. Nursing care must be recorded on resident's chart.

TOOLS AND EQUIPMENT:

Brush	Mirror	Comb
Towel	Hair accessories	Resident's chart

PERFORMANCE GUIDE:

1. Introduce self

2. Verify resident's identity and explain procedure

3. Assemble resident brush, comb, hair accessories and equipment

4. Place towel around resident's shoulder or under resident's head

5. Brush and comb resident's hair
   a. Divide hair into small sections
   b. Hold hair firmly above area you are combing
   c. Wet matted hair slightly to facilitate combing
   d. Part and arrange hair per resident's preference

6. Show resident hair in mirror

7. Assure resident comfort/call bell within reach

8. Wash comb and brush

9. Return equipment to storage

10. Wash hands

Student Name_____

TASK:

Hair Care – Styling (Comb and Brush)

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Identified resident		
4. Explained procedure for hair care		
5. Combed/brushed hair in prescribed manner and per resident's preference		
6. Positioned resident and equipment to assure comfort and safety of resident		
7. Cleaned and replaced equipment		
8. Recorded/reported pertinent observations		
9. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the hair of the resident is combed/brushed according to the procedure of the training program and the achievement indicators listed.

TASK:
Shaving – Blade Razor

STANDARD:
Resident must be shaved with minimum skin irritation. Any nicks must be reported. Procedure must be recorded on resident's chart.

TOOLS AND EQUIPMENT:

After shave lotion	Razor	Antiseptic	Shaving cream
Basin of hot water	Towels	Washcloth	Resident's chart

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Provide privacy
4. Wash hands
5. Assemble equipment and supplies at bedside
6. Adjust lighting
7. Raise head of bed
8. Spread towel under resident's chin
9. Soften beard with warm water for 3-5 minutes by applying warm washcloth or face towel
10. Apply shaving lather
11. Hold skin taut and shave in direction of hair growth (Caution: Use firm short stokes)
12. Rinse razor often
13. Wash resident's face when shave is finished
14. Pat dry
15. Apply after shave lotion if requested

16. Offer mirror to resident
17. Assure resident comfort/call bell with reach
18. Clean adn return equipment and supplies
19. Clean area
20. Wash hands

Student Name_____

TASK:

Shaving – Blade Razor

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Assembled equipment for shaving		
4. Greeted resident and explained procedure		
5. Screened resident for privacy		
6. Performed shave in prescribed manner		
7. Rinsed face and dried well		
8. Cleaned and replaced equipment		
9. Recorded procedure		
10. Assured resident comfort and safety/call bell within reach		
11. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when each achievement indicator has been demonstrated satisfactorily.

TASK:
Perineal Care – Male

STANDARD:
Perineal care must be provided to ensure resident privacy and dignity. The perineal area must be clean and dry.

TOOLS AND EQUIPMENT:

Soap dish and soap	Waterproof pad	Bath towel
Disposable bag	Bath blanket	Clean disposable gloves

Washcloth (or disposable washcloths or cotton balls if available)

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Provide privacy
4. Wash hands
5. Arrange equipment and supplies
6. Raise the bed to the appropriate level for proper body mechanics
7. Lower the side rail on the side near you
8. Remove soiled or wet linen from the bed
9. Cover the resident with a bath blanket. Move top linens to the foot of the bed.
10. Position the resident on his back. Place a waterproof pad under his buttocks
11. Drape the resident:
    a. Position the bath blanket with one corner between the resident's legs. There should be a corner on each side of the bed and a corner at the neck
    b. Wrap the bath blanket around his far leg by bringing the corner around the leg and tucking it under the hip
    c. Drape the near leg in the same manner
12. Raise the side rail
13. Fill the was basin with water 105 to 109 degree F (41 to 43 degree C)

14. Place the wash basin on the overbed table on top of the paper towels

15. Put the washcloths in the wash basin

16. Lower the side rail

17. Help the resident flex his knees and spread his legs, if he is able. Otherwise, help him spread his legs as much as possible with his knees straight

18. Put on the disposable gloves

19. Fold the corner of the bath blanket between the resident's legs onto his abdomen

20. Apply soap to a washcloth

21. Grasp the penis

22. Retract the foreskin if the resident is uncircumcised

23. Clean the tip of the penis using a circular motion. Start at the urethral opening and work outward. Use fresh side of washcloth for each stroke. Repeat this step as necessary.

24. Rinse the area with another washcloth

25. Return the foreskin to its natural position if the resident is uncircumcised

26. Clean the shaft of the penis with firm downward strokes

27. Cleanse the scrotum and rinse well

28. Pat dry the penis and scrotum

29. Fold the center corner of the blanket back between the resident's legs

30. Help the resident lower his legs and turn onto his side away from you

31. Clean the anal area by cleaning from scrotum to anus. Rinse the anal area with a washcloth and dry well. Discard the washcloth

32. Remove the gloves and discard into the bag

33. Position the resident so that he is comfortable

34. Return the bed linens to their proper position and remove the bath blanket

35. Raise the side rail. Make sure the signal light is within the resident's reach

36. Lower the bed to its lowest horizontal position

37. Empty and clean the wash basin. Return it and other supplies to their proper place

38. Wipe off the overbed table with the paper towels and then discard them

39. Unscreen the resident

40. Take soiled linen and the disposable bag to the soiled utility room

41. Wash your hands

42. Report your observations to the nurse:
    a. Odors
    b. Redness, swelling, discharge, or irritation
    c. Resident complaints of pain, burning or other discomfort

Student Name_____

TASK:

Perineal Care – Male

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Provided privacy		
3. Explained procedure		
4. Assembled equipment		
5. Washed hands before and after procedure		
6. Draped resident appropriately		
7. Wore gloves/observed universal precautions		
8. Washed, rinsed, dried penis and scrotum appropriately		
9. Washed, rinsed, dried anal area appropriately		
10. Cleaned and replaced equipment/observed universal precautions		
11. Positioned resident to insure comfort and safety (call bell within reach)		
12. Recorded procedure		
13. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when it is performed according to achievement indicators and/or facility policy

TASK:
Perineal Care – Female

STANDARD:
Perineal care must be provided in a manner which ensures resident privacy and dignity. The perineal area must be clean and dry.

TOOLS AND EQUIPMENT:

Soap dish and soap	Waterproof pad	Bath towel
Disposable bag	Bath blanket	Clean disposable gloves

Washcloth (or disposable washcloths or cotton balls if available)

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Provide privacy
4. Wash hands
5. Arrange equipment and supplies at bedside
6. Raise the bed to the appropriate level for proper body mechanics
7. Lower the side rail on the side near you
8. Remove soiled or wet linen from the bed
9. Cover the resident with a bath blanket. Move top linens to the foot of the bed.
10. Position the resident on her back. Place a waterproof pad under her buttocks
11. Drape the resident:
    a. Position the bath blanket with one corner between the resident's legs. There should be a corner on each side of the bed and a corner at the neck
    b. Wrap the bath blanket around her far leg by bringing the corner around the leg and tucking it under the hip
    c. Drape the near leg in the same manner
12. Raise the side rail

13. Fill the was basin with warm water

14. Place the wash basin on the overbed table on top of the paper towels

15. Put the washcloths in the wash basin

16. Lower the side rail

17. Help the resident flex her knees and spread her legs, if she is able. Otherwise, help her spread her legs as much as possible with her knees straight

18. Put on the disposable gloves

19. Fold the corner of the bath blanket between the resident's legs onto her abdomen

20. Apply soap to a washcloth

21. Separate the labia. Clean downward from front to back with one stroke. Discard the washcloth

22. Repeat steps 21 and 22 until the area is clean

23. Rinse the perineum with a washcloth. Separate the labia. Stroke downward from front to back. Use fresh side of washcloth for each stroke and repeat this step as necessary.

24. Pat the area dry with the towel

25. Fold the center corner of the blanket back between the resident's legs

26. Help the resident lower her legs and turn onto her side away from you

27. Apply soap to a washcloth

28. Clean anal area by cleaning from the vagina to the anus with one stoke.

29. Dispose of the washcloth as appropriate

30. Rinse the anal area with a washcloth. Stroke from the vagina to the anus. Discard the washcloth. Repeat the steps as necessary

31. Pat the area dry with the towel

32. Remove the gloves and discard into the bag

33. Position the resident so that she is comfortable

34. Return the bed linens to their proper position and remove the bath blanket

35. Raise the side rail. Make sure the signal light is within the resident's reach

36. Lower the bed to its lowest horizontal position

37. Empty and clean the wash basin. Return it and other supplies to their proper place

38. Wipe off the overbed table with the paper towels and then discard them

39. Unscreen the resident

40. Take soiled linen and the disposable bag to the soiled utility room

41. Wash your hands

42. Report your observations to the nurse:
    a. Odors
    b. Redness, swelling, discharge, or irritation
    c. Resident complaints of pain, burning or other discomfort

Student Name_____

TASK:

Perineal Care – Female

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Provided privacy		
3. Explained procedure		
4. Assembled equipment		
5. Washed hands before and after procedure		
6. Draped resident appropriately		
7. Wore gloves/observed universal precautions		
8. Washed, rinsed, and dried perineal area appropriately (cleaned from front to back)		
9. Washed, rinsed, dried anal area appropriately (cleaned from front to back)		
10. Cleaned and replaced equipment/observed universal precautions		
11. Positioned resident to insure comfort and safety (call bell within reach)		
12. Recorded procedure		
13. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when it is performed according to achievement indicators and/or facility policy

TASK:
Bathing/Tub – Shower

STANDARD:
Water must be warm, bath mat must be in place and resident must demonstrate understanding of faucets, safety handles, and shower chair. Resident must be clean and dry. Bathing area must be left clean and ready for use. Procedure must be recorded on resident's chart

TOOLS AND EQUIPMENT:

Bath mat	Robe	Call button	Shower chair	Soap
Cleaning supplies	Deodorant	OCCUPIED sign	Washcloth	Towel
Shower or bathtub	Resident's chart			

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Wash hands
4. Assemble supplies
5. Provide privacy
6. Assist resident to remove clothes and put on robe
7. Accompany resident to bathing room
8. Explain use of equipment:
   a. Faucets
   b. Safety handles
   c. Shower chair
   d. Call button
9. Place OCCUPIED sign on door
10. Place bath mat in front of tub or shower
11. Check to insure that area is clean
12. Fill tub halfway with warm water
    a. For showers, adjust flow and temperature of water

13. Inquire about allergies and supply required non-allergenic soap

14. Provide privacy

15. Assist resident to bathe if condition so dictates

Caution: Do not leave resident unattended if condition dictates close observation

16. Instruct resident to call when ready

Note: Return periodically if not called.

17. Assist resident with drying

18. Assist resident in applying deodorant

19. Assist resident in dressing

20. Accompany resident to room

21. Assure resident comfort

22. Clean bathing area

23. Wash hands

24. Remove OCCUPIED sign

25. Record care

Student Name_____

TASK:

Bathing/Tub – Shower

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduce self		
2. Washed hands before and after procedure		
3. Identified resident and explained procedure		
4. Assembled supplies and equipment		
5. Provided privacy for resident		
6. Prepared resident for tub bath or shower		
7. Accompanied resident to bathing or shower room		
8. Assisted resident with tub bath or shower according to the needs/condition of the resident in prescribed manner		
9. Positioned resident and equipment to assure comfort and safety		
10. Dressed resident		
11. Cleaned bath area		
12. Recorded/reported procedure and any pertinent observation		
13. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident has been bathed according to the procedure of the training program and the achievement indicators listed.

TASK:
Bathing – Bed

STANDARD:
Medical asepsis must be maintained during bed bath. Resident must be clean and dry. Procedure must be recorded on resident's chart.

TOOLS AND EQUIPMENT:

Bath blanket	Orange stick	Bath powder	Soap
Q-tips	Bed linen	Resident's chart	Lotion
Bedpan or urinal	Wash basin	Gown/pajamas	Towels
Washcloths			

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Close windows and doors (check temperature of room)
4. Assemble equipment and supplies
5. Provide privacy
6. Offer bedpan or urinal
7. Wash hands
8. Drape resident with bath blanket
9. Make resident comfortable
10. Fill wash basin 2/3 full with warm water (check temperature)
11. Place a towel under resident's chin (lengthwise across chest)
12. Wash face (use soap per resident preference)
13. Rinse and dry face
14. Remove resident's gown or pajamas

Note: Resident may wish to bathe unaided

15. Expose far arm and hand, place towel under arm and hand
16. Bathe resident's far arm and axillae (use soap sparingly)
17. Rinse and dry arm and axillae (cover shoulder with blanket)
18. Soak far hand in basin and clean nails
19. Rinse and dry hand
20. Cover far arm and hand with blanket
21. Expose near arm and hand, place towel under arm and hand
22. Repeat procedure for near arm, axillae and hand (Steps 15-20)
23. Fold bath blanket down and place towel lengthwise across resident's chest
24. Bathe chest (use soap sparingly)
25. Rinse and dry chest
26. Powder/lotion resident as condition dictates
27. Bathe abdomen using Q-tip for navel (use soap sparingly)
28. Rinse and dry abdomen
29. Cover chest and abdomen with bath blanket
30. Fold bath blanket back and expose far thigh, leg and foot
31. Place towel beneath far thigh, leg and foot
32. Bathe leg and thigh (use soap sparingly)
33. Rinse and dry thigh and leg
34. Cover far thigh and leg with bath blanket
35. Soak far foot in basin
36. Check condition of toenails and skin

37. Rinse and dry foot thoroughly

38. Cover foot with bath blanket

39. Expose near thigh, leg and foot

40. Place towel beneath resident's near thigh, leg and foot

41. Repeat procedure for near thigh, leg and foot (Steps 30-38)

42. Change bath water

43. Position resident facing away (turn resident on side)

44. Place towel close to resident's back

45. Bathe resident's back (use soap sparingly)

46. Rinse, dry, and powder/lotion as condition dictates

47. Cover resident's back with bath blanket

48. Expose perineal area

49. Place towel beneath buttocks

50. Administer perineal and anal care

Note: Resident may wish to complete this part

51. Assist resident to redress in clean gown/pajamas

52. Clean area

53. Assure resident's comfort and leave call bell within reach

54. Clean and return equipment to storage

55. Wash hands

56. Record care and pertinent observation

Note:

a. Always change bath water if it is too dirty, too soapy, or too cold
b. Don't expose resident unnecessarily
c. Keep resident warm and dry during procedure

Student Name_____

TASK:

Bathing – Bed

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Explained bed bath procedure		
4. Assembled equipment		
5. Adjusted room temperature and eliminated drafts if necessary		
6. Screened resident for privacy		
7. Performed bed bath procedure in prescribed manner using proper body mechanics		
8. Positioned resident and equipment to assure comfort and safety of resident; call bell within reach		
9. Dressed resident		
10. Cleaned and replaced equipment		
11. Recorded/reported procedure and any pertinent observations		
12. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when a resident's skin is cleansed according to the procedure of the training program and the achievement indicators listed.

TASK:
Skin Care/Inspection

STANDARD:
Resident's skin must be clean and dry with any abnormalities or reddened areas on shoulders, elbows, hips, coccyx and heels noted and reported.

TOOLS AND EQUIPMENT:
Bath blanket Resident's chart

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Provide privacy
4. Cover resident with bath blanket
5. Remove clothing as necessary
6. Inspect resident's skin, particularly the bony prominences of shoulders, elbows, hips, coccyx and heels
7. Replace clothing
8. Assure resident's comfort and safety/call bell within reach
9. Record all observations
10. Report observations/abnormalities to nurse

Student Name_____

TASK:

Skin Care/Inspection

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Identified resident		
4. Explained purpose and procedure for skin inspection		
5. Screened resident for privacy		
6. Inspected designated skin area noting any abnormalities		
7. Recorded/reported any abnormalities		
8. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when any abnormal conditions of a resident's skin are detected according to the procedure of the training program and the achievement indicators listed.

TASK:
Dressing

STANDARD:
Resident must be provided with privacy. Procedure must be recorded on resident's chart. Resident must be dressed neatly and appropriately.

TOOLS AND EQUIPMENT:
Resident's chart Resident's clothing or hospital gown

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Wash hands
4. Provide privacy
5. Offer resident choice/preference for clothing as appropriate
6. Remove soiled garments, draping resident appropriately
7. Put on undergarments or assist as needed
8. Assist resident to put on clean clothing or gown, per resident preference as appropriate
9. Collect soiled garments and dispose of accordingly
10. Wash hands
11. Assure resident comfort and safety – call bell within reach
12. Chart care/observations

Note: If resident has a one-sided weakness, support affected side during dressing

Student Name_____

TASK:

Dressing

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Identified resident and explained procedure		
4. Assembled clothing in prescribed manner and offered resident preference		
5. Screened resident for privacy		
6. Assisted resident to dress per resident ability and preference		
7. Appropriate undergarments offered/placed on resident		
8. Resident dressed neatly and appropriately		
9. Positioned resident and equipment to assure comfort and safety of resident/call bell within reach		
10. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when resident is assisted to dress according to the procedure of the training program and the achievement indicators listed.

TOOLS AND EQUIPMENT:

See Laboratory Sheets

TASK:
Bed Operation

STANDARD:
The nursing assistant will appropriately operate a bed for height and/or position.

TOOLS AND EQUIPMENT:
Electric bed Manual bed

PERFORMANCE GUIDE:

1. Wash hands

2. Manual bed
   a. Locate cranks
   b. Use cranks to adjust bed height
   c. Use cranks to position the bed in Fowler's position

3. Electric bed
   a. Locate control unit
   b. Use control unit to adjust bed height
   c. Use control unit to position the bed in Fowler's position

4. Safety considerations
   a. Adjust bed to comfortable working height for nursing assistant
   b. Always return bed to low position for resident safety and comfort
   c. Check with charge nurse on use of knee gatch
   d. Return cranks to down position

Student Name_____

TASK:

Bed Operation

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Washed hands before and after task		
2. Located cranks or control unit		
3. Adjusted bed for height and position		
4. Followed safety guidelines for bed operations		

CRITERIA:

Competency will be recognized when the bed can be adjusted for height and position safely.

TASK:
Making an occupied bed

STANDARD:
Linens on resident's bed must be clean and neat; corners must be mitered. Pillow must be at head of bed with open end of pillowcase away from door.

TOOLS AND EQUIPMENT:

Bedspread	Mattress	Draw sheet	Mattress pad
Flat sheets	Pillow	Linen bag	Pillowcase

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Wash hands
4. Assemble linens on clean surface near bed
5. Adjust bed to comfortable work height
6. Remove bedspread
7. Loosen top sheet at foot of bed
8. Remove pillow
9. Pull up side rails on far side of bed
10. Assist resident to far side of bed, facing away from you
11. Loosen bottom linens on side opposite resident
12. Slide mattress toward head of bed
13. Tighten mattress pad or replace soiled pad
14. Fanfold soiled linen close to resident's body
15. Fanfold half of bottom sheet lengthwise
16. Place fanfolded length of bottom sheet along side of fanfolded soiled linen

Note: Lower hem of sheet should be even with bottom of mattress. Seams should be facing toward mattress.

17. Tuck sheet under mattress at head of bed

18. Miter corner at head of bed

19. Fold draw sheet

20. Fanfold draw sheet and place fanfold on top of fanfold bottom sheet

21. Tuck side of draw sheet and side of bottom sheet together under mattress

22. Pull up side rail on side you were working on

23. Turn resident over linen mound toward clean side of bed

24. Move to opposite side of bed and lower side rail

25. Remove soiled bottom linen from bed, place in linen bag and close top

26. Pull all clean linen toward you

27. Miter corner of bottom sheet at head of bed

28. Tuck bottom sheet and draw sheet smoothing out wrinkles

29. Remove soiled pillowcase from pillow and replace with clean pillowcase

30. Assist resident to comfortable position

31. Place pillow under resident's head, with open end of pillowcase away from door

32. Spread clean top sheet over resident

33. Pull soiled top linen out toward foot of bed

34. Tuck top linens at foot of bed if condition dictates (make toe pleat)

35. Fold top sheet back over top edge of bedspread

36. Assure resident comfort and safety
    a. Lower bed to lowest horizontal position
    b. Pull up side rails per care plan
    c. Call bell within reach

37. Remove linen bag to area designated for soiled linen

38. Wash hands

Student Name_____

TASK:

Making an occupied bed

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Explained procedure		
4. Screened resident for privacy		
5. Changed linens in prescribed manner using proper body mechanics		
6. Positioned resident and equipment to assure comfort and safety of resident/call bell within reach		
7. Disposed of soiled linens		
8. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident's bed is changed according to the procedure of the training program and the achievement indicators listed.

TASK:
Making an unoccupied bed

STANDARD:
Linens must be smooth, neat and without wrinkles; corners must be mitered. Pillow must be at head of bed with open end of pillowcase away from door.

TOOLS AND EQUIPMENT:

Bed	Mattress pad	Bedspread	Pillow
Linen bag	Pillowcase	Mattress	Two flat sheets

PERFORMANCE GUIDE:

1. Wash hands
2. Assemble linens
3. Place linens on clean surface
4. Adjust bed to comfortable work height
5. Remove soiled linen for bed
6. Placed soiled linen in linen bag and close bag
7. Slide mattress toward head of bed
8. Secure mattress pad on bed with absorbent side up
9. Place bottom sheet on bed with fold down center of mattress and seams toward mattress
10. Adjust bottom sheet so that lower hem of sheet is even with bottom edge of mattress
11. Tuck sheet under mattress at head of bed
12. Miter corner at head of bed
13. Tuck sheet under mattress along one side (position and tuck draw sheet, if any)
14. Place top sheet on bed with fold down center
15. Adjust top sheet so that top hem is even with top edge of mattress

16. Place bedspread on bed with fold down center so that top hem is even with top edge of mattress

17. Tuck linens under bottom of mattress

18. Miter corner of top linens at foot of bed

19. Repeat procedure on other side of bed

20. Fanfold top linens to bottom of bed

21. Insert pillow in pillowcase

22. Position pillow at head of bed with open end of pillowcase away from door

23. Adjust bed to height to receive patient
    a. Adjust to lowest position to receive ambulatory patient
    b. Adjust to highest position to receive patient from stretcher

24. Remove linen bag to area designated for soiled linen

25. Wash hands

Student Name_____

TASK:

Making an unoccupied bed

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Washed hands before and after procedure		
2. Assembled supplies		
3. Changed linens in prescribed manner using proper body mechanics		
4. Disposed of soiled linens		

CRITERIA:

Competence in the task will be recognized when the bed is changed according to the procedure of the training program and the achievement indicators listed.

TASK:
Application/Removal Physical Restraints (Vest and Waist Restraints) – Resident in wheelchair

STANDARD:
Vest and waist devices must be ordered by the physician. Protective devices must not interfere with treatment or health problems. Application of protective devices must be recorded on resident's chart and resident must be released, exercised and checked every two hours.

TOOLS AND EQUIPMENT:
Protective devices (vest and waist restraint) Resident's chart

PERFORMANCE GUIDE:
Note: Applying protective devices has serious implications and agency procedures must be followed.

1. Check care plan regarding use of restraints

2. Introduce self

3. Verify resident's identity and explain procedure

4. Assure resident and support person/family that protective devices are temporary and used only for resident safety

5. Wash hands

6. Provide privacy
   a. Apply vest restraint
      (1) Place vest over resident's gown
      (2) Ensure that gown and vest are not wrinkled
      (3) Secure straps using slip knot tie (square knot)
      (4) Check restraint – not too loose or too tight
      (5) Make sure resident comfortable and in good body alignment
      (6) Place call bell within resident's reach
      (7) Remove restraint every 2 hours, exercise and toilet resident
   b. Apply waist/belt restraint
      (1) Obtain a waist belt restraint in a size appropriate for the resident
      (2) Assist the resident to a sitting position by locking arms with the resident
      (3) Place the belt around the front of the resident's waist. Bring the ties to the back with your free hand
      (4) Make sure there are no wrinkles in the front or back of the restraint
      (5) Bring the ties through the slots

(6) Make sure the resident is comfortable and in good body alignment
(7) Tie the straps to non-movable part of wheelchair using a slip knot/square knot
(8) Place the signal light with the resident's reach
(9) Unscreen the resident
(10) Wash your hands
(11) Remove the restraints every 2 hours and reposition the resident. Give skin care, perform range of motion exercise, and reapply the restraint
(12) Record and report your observations to the nurse

Student Name_____

TASK:

Application/Removal Physical Restraints (Vest, Waist Restraint)

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Assembled supplies and equipment		
4. Identified resident and explained procedure		
5. Screened resident for privacy		
6. Applied protective devices in prescribed manner		
7. Positioned resident and equipment to assure comfort and safety of resident – call bell within reach		
8. Recorded/reported procedure and pertinent observations		
9. Verbalized frequency and importance of checking, releasing, toileting, exercising resident every 2 hours		
10. Removed restraint in prescribed manner		
11. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when protective devices are applied according to the procedure of the training program and the achievement indicators listed.

TASK:
Take/Record Temperature – Oral – Axillary – Rectal

STANDARD:
Glass mercury thermometers must be shaken down before temperature is taken. Oral temperatures must be taken for 3 minutes; axillary temperatures must be taken for 10 minutes; and rectal temperatures must be taken for a minimum of 3 minutes. Manufacturer's instructions must be followed for other than mercury thermometer devices. Resident's temperature must be recorded.

TOOLS AND EQUIPMENT:

Lubricant (if necessary)	Resident's chart	Pencil/pen
Thermometer	Work sheet	

PERFORMANCE GUIDE:

1. Introduce self

2. Verify resident's identity and explain procedure

3. Wash hands

4. Assemble equipment

5. Write resident's name and room number on work sheet

6. Take resident's temperature
   a. Oral temperature using glass mercury thermometer:
      (1) Rinse thermometer with cool water
      (2) Check level of mercury and shake down below 95 degrees if necessary
      (3) Place under resident's tongue for 3 minutes

   b. Axillary temperature using glass mercury thermometer:
      (1) Check level of mercury and shake down below 95 degrees if necessary
      (2) Place thermometer under resident's armpit
      (3) Hold patient's arm tightly against chest
      (4) Leave thermometer in place for 10 minutes

   c. Rectal temperature using glass mercury thermometer:
      (1) Check level of mercury and shake down below 95 degrees if necessary
      (2) Lubricate bulb end of thermometer
      (3) Place resident in Sim's position

(4) Insert thermometer in rectum 1-1/2 inches
(5) Hold thermometer in place 3 – 5 minutes
(6) Wipe excess lubricant from anal area when thermometer is removed

7. Remove thermometer and wipe thermometer from fingers toward bulb

8. Read thermometer

9. Shake down mercury thermometer

10. Record temperature on work sheet, clean glass thermometer per facility procedure

11. Assure resident's comfort and leave call bell within reach

12. Wash hands

13. Report abnormal reading to nurse

14. Record temperature on appropriate form

Student Name_____

TASK:

Take/Record Temperature: Oral – Axillary – Rectal

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Washed hands before and after procedure		
2. Introduced self		
3. Assembled equipment		
4. Identified resident		
5. Explained procedure for taking temperature		
6. Took temperature in prescribed manner		
7. Cleaned and replaced equipment		
8. Record/reported temperature and any pertinent observations		
9. Call bell within reach		
10. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the temperature of resident is taken according to the procedure of the training program and the achievement indicators listed.

TASK:
Take/Record Pulse

STANDARD:
Regular pulsation must be counted for 60 seconds. All readings must be recorded.

TOOLS AND EQUIPMENT:
Pencil/pen Scratch pad Resident's chart Watch with second hand

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Wash hands
4. Place two or three fingers over radial artery
5. Count pulsations for 60 seconds using watch with second hand
6. Recount pulsations if pulse is irregular
7. Note regularity and strength of beat
8. Record pulse rate on worksheet
9. Assure resident's comfort, leave call bell within reach
10. Wash hands
11. Report abnormal readings and irregularities to nurse
12. Record pulse rate on appropriate form

Student Name_____

TASK:

Take/Record Pulse

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Assembled equipment		
4. Identified resident		
5. Explained procedure for taking pulse		
6. Took pulse in prescribed manner		
7. Record/reported pulse and any pertinent observations		
8. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the pulse rate of a resident is obtained according to the procedure of the training program and the achievement indicators listed.

TASK:
Take/Record Respiration

STANDARD:
Respiration must be counted for 60 seconds. All readings must be recorded.

TOOLS AND EQUIPMENT:
Pencil/pen Scratch pad Resident's chart Watch with second hand

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Wash hands
4. Keep fingers on resident's wrist while counting respirations
5. Count resident's respirations for 60 seconds
6. Note depth and rhythm of respirations
7. Record respiration rate on worksheet
8. Assure resident's comfort and leave call bell within reach
9. Wash hands
10. Report abnormal findings and irregularities to nurse
11. Record respiration rate on appropriate form

Student Name_____

TASK:

Take/Record Respirations

ACHIEVEMENT INDICATORS: The Trainee:

1.	Introduced self and explained procedure	Yes	No
2.	Identified resident	Yes	No
3.	Counted respirations in prescribed manner	Yes	No
4.	Recorded/reported respirations and any pertinent observations	Yes	No
5.	Used appropriate physical and verbal contact	Yes	No

CRITERIA:

Competence in the task will be recognized when the respirations of a resident are assessed according to the procedure of the training program and the achievement indicators listed.

TASK:
Take/Record Blood Pressure

STANDARD:
Ear pieces and diaphragm of stethoscope must be cleaned before and after blood pressure is taken. Sphygmomanometer cuff must be places at least 1 inch above elbow. All readings must be recorded on resident's chart.

TOOLS AND EQUIPMENT:

Antiseptic	Scratch pad	pencil/pen	Sphygmomanometer
Resident's chart	Stethoscope		

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Wash hands
4. Assemble equipment
5. Clean ear pieces and diaphragm of stethoscope with antiseptic
6. Locate brachial artery at inner aspect of elbow
7. Wrap deflated cuff smoothly and snugly around resident's upper arm
   a. Place cuff at least 1 inch above elbow
   b. Center over brachial artery
8. Faster cuff securely
9. Place ear pieces of stethoscope in your ear
10. Place diaphragm of stethoscope over artery
11. Locate radial artery with fingertips
12. Close valve on air pump
13. Pump air bulb to inflate cuff until you can no longer feel the radial pulse and inflate cuff 30 mm Hg beyond the point at which you last felt the pulse
14. Deflate cuff slowly and at constant rate (2 –4 mm per second)

15. Watch numerical line of sphygmomanometer as mercury falls

16. Listen for first thumping sound in stethoscope

17. Note exact numerical line where first thump (systolic pressure) is heard
    a. For aneroid sphygmomanometers, read dial when first thump is heard

18. Note exact numerical line where last clear thump (diastolic pressure) is heard

19. Repeat steps 11-18 if necessary, pausing 30 seconds between attempts

20. Record reading on worksheet

21. Remove cuff

22. Assure resident comfort and leave call bell within reach

23. Wash hands

24. Clean and return equipment to storage

25. Report abnormal readings to nurse

26. Record blood pressure on appropriate form

Student Name_____

TASK:

Take/Record Blood Pressure

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Assembled equipment		
4. Identified resident		
5. Explained procedure		
6. Took blood pressure in prescribed manner		
7. Obtained an accurate reading		
8. Cleaned and replaced equipment		
9. Reported/recorded blood pressure reading		
10. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the blood pressure is measured according to the procedure of the training program and the achievement indicators listed.

TASK:
Take/Record Resident's height and weight

STANDARD:
Scales must be balanced and must be stationary and paper towel must be in place before resident steps onto platform. Measurements must be recorded on resident's chart.

TOOLS AND EQUIPMENT:
Paper towel Resident's chart Scales

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Wash hands
4. Assemble equipment
5. Provide privacy
6. Balance scales
7. Ensure scale is in stationary position
8. Place paper towel or other appropriate covering on platform if resident is barefoot
9. Assist resident onto scale
10. Steady resident

Note: Resident must not be leaning and holding supports during measurements

11. Read scales (note weight)
12. Record weight on worksheet
13. Raise measurement bar, rest gently on top of resident's head
14. Measure height
15. Record height on worksheet
16. Adjust scales

17. Assist resident off scale
18. Assure resident comfort
19. Return scales to storage area
20. Wash hands
21. Record measurements on appropriate form

Student Name_____

TASK:

Take/Record Resident's Height and Weight

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self and explained procedure		
2. Washed hands before and after procedure		
3. Assembled equipment		
4. Performed height and weight procedure in prescribed manner		
5. Positioned resident and equipment to assure safety and comfort of resident		
6. Recorded accurate measurements		
7. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident's height and weight is obtained according to the procedure of the training program and the achievement indicators listed.

TASK:
Feed Resident

STANDARD:
Resident must be fed prescribed diet and food intake must be noted on resident's chart. Resident's face, hands, clothes and bed linen must be clean after procedure. Procedure must be recorded on resident's chart.

TOOLS AND EQUIPMENT:
Bib Napkin Food tray Resident's chart Towel

PERFORMANCE GUIDE:

1. Introduce self

2. Verify resident's identity and explain procedure

3. Cross-check resident identification with labeled food tray and verify prescribed diet

4. Wash hands

5. Assist resident to wash his/her hands

6. Provide towel, bib, or napkin

7. Adjust bed tray (elevate head of bed to safe and comfortable eating position)

8. Place food on tray

9. Ask resident preference for condiments, etc.

10. Cut resident food as needed and prepare beverages, etc.

11. Allow resident time to eat; observe for swallowing difficulty/choking

12. Feed resident as needed using small bites and adequate time to chew and swallow

13. Remove towel, bib or napkin and food tray

14. Assist resident to clean hands and face

Note: Observe what and how much is eaten

15. Clean area

16. Wash hands

17. Assure resident comfort and safety (call bell and side rails)

18. Chart resident food intake

Student Name_____

TASK:

Feed Resident

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Identified resident and proper diet		
4. Prepared resident for meal		
5. Served proper tray to resident		
6. Fed resident in prescribed manner		
7. Allowed adequate time for resident to chew and swallow		
8. Allowed for resident preferences		
9. Assisted resident to clean hands and face before and after eating		
10. Removed food tray and cleaned area		
11. Positioned resident and equipment to assure comfort and safety/call bell within reach		
12. Recorded/reported food intake		
13. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when a resident is fed in order to provide adequate nutrition according to the procedure of the training program and the achievement indicators listed.

TASK:
Measure/Record Intake and Output

STANDARD:
Fluid intake and output must be measured and recorded accurately. The nurse must be notified if inadequate intake or output is recorded.

TOOLS AND EQUIPMENT:

Bedpan, urinal, or specimen pan	Intake and output flowsheet
Resident's chart	Graduated measuring container

Intake and output sheet on resident's chart

PERFORMANCE GUIDE:

1. Check care plan
2. Obtain intake and output flowsheet
3. Fill in specified information
4. Introduce self
5. Verify resident's identity and explain importance of accuracy
6. Place intake and output flowsheet in resident area
7. Place graduated measuring container in resident's bathroom
8. Instruct resident to save all urine voided
9. Record all fluids taken by mouth
10. Measure and record all output in appropriate container
11. Total and record on resident's chart at end of 8 hour shift:
    a. All intake by mouth
    b. All output (urine, emesis)
12. Notify nurse if intake and/or output is abnormal

Student Name_____

TASK:

Measure/Record Intake and Output

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Washed hands before and after procedure		
2. Identified resident		
3. Explained procedure for measuring fluid intake and fluid output		
4. Identified all sources of fluid intake and fluid output		
5. Monitored fluid intake and fluid output in a prescribed manner		
6. Accurately computed fluid intake and fluid output in prescribed manner		
7. Disposed of fluid output		
8. Cleaned and replaced equipment		
9. Recorded/reported fluid intake and fluid output and any pertinent observations		
10. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the fluid intake and fluid output of a resident is documented and reported accurately according to the procedure of the training program and the achievement indicators listed.

TASK:
Assist with Bedpan/Urinal

STANDARD:
Nurse must respond promptly to resident's call for assistance in using bedpan/urinal. Resident's perineal area and hands must be clean. Bed linens must not be soiled. Contents of bedpan/urinal must be charted.

TOOL AND EQUIPMENT:

Air freshener	Soap	Disposable gloves	Bedpan/urinal	Towel
Toilet tissue	Washcloth	Cleaning solution	Resident's chart	

PERFORMANCE GUIDE:

1. Respond to resident's call for assistance and introduce self

2. Wash hands

3. Assemble equipment at bedside

4. Provide privacy

5. Adjust bed clothes (fold bed linens to one side)

6. Position resident with hips raised and knees flexed

7. Slide bedpan under resident (check placement of pan)

Note: If not possible:
Turn resident onto side
Place bedpan close to buttocks
Roll resident onto bedpan

8. Replace bed linen over resident

9. Raise head of bed as condition permits

10. Place call button and toilet tissue within resident's reach

11. Raise side rails

12. Instruct resident to call when ready

Note: Return in 5-10 minutes if not called

13. Instruct resident to position urinal so that urine flows into urinal (position urinal if resident is unable)

14. Put on disposable gloves

15. Remove bedpan/urinal without spillage and observe contents

16. Provide for perineal cleansing

17. Empty bedpan/urinal (soak in cleaning solution)

18. Clean bedpan/urinal and return to storage

19. Remove gloves

20. Assist resident in washing hands

21. Clean area

22. Assure resident's comfort and safety (side rails and call bell)

23. Spray area with air freshener if necessary

24. Wash hands

25. Chart/report observations

Student Name_____

TASK:

Assist with Bedpan/Urinal

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Assembled equipment		
4. Screened resident for privacy		
5. Assisted to use bedpan/urinal in prescribed manner		
6. Positioned resident and equipment to assure safety and comfort of resident/call bell within reach		
7. Checked contents of bedpan/urinal for amount, color, consistency, and abnormal characteristics		
8. Assisted resident to wash hands and provided for perineal cleaning		
9. Recorded/reported any pertinent observations of bedpan/urinal contents		
10. Cleaned bedpan/urinal and replaced equipment in designated area		
11. Observed universal precautions as appropriate		
12. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when resident is assisted to use bedpan/urinal according to the procedure of the training program and the achievement indicators listed.

TASK:
Assist with Bedside Commode/Toilet

STANDARD:
Nurse aide must respond promptly to resident's call for assistance. Resident must be safely assisted in using bedside commode or toilet. Resident's perineal area and hands must be clean and contents of commode must be charted.

TOOLS AND EQUIPMENT:

Air freshener	Soap	Disposable gloves	Bedside commode
Toilet tissue	Towel	Cleaning supplies	Resident's chart
Washcloth			

PERFORMANCE GUIDE:

1. Respond to resident's call for assistance and identify self
2. Verify resident's identity and explain procedure
3. Wash hands
4. Assemble equipment
5. Adjust bed to lowest position
6. Provide privacy
7. Position commode parallel to bed
8. Fold bed linens to foot of bed
9. Assist resident to dangle
10. Assist resident to stand, turn, and sit on commode or to ambulate to bathroom using appropriate transfer technique or ambulation assistance

Caution: Do not leave resident unattended if condition dictates close observation

11. Place call button and toilet tissue with reach
12. Instruct resident to call when ready

Note: Return in 5-10 minutes if not called

13. Wash hands/put on gloves as needed

14. Assist resident in cleansing perineal area as necessary

15. Assist resident to return to bed

16. Assist resident to wash hands

17. Observe contents of commode/toilet

18. Assure resident comfort and safety (call bell)

19. Clean area and freshen air as necessary

20. Clean commode using gloves and return to storage

21. Wash hands

22. Record and report any unusual color, texture or odor of urine or feces or according to physician's orders

Student Name_____

TASK:

Assist with Bedside Commode/Toilet

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Assembled equipment		
4. Screened resident for privacy		
5. Used appropriate transfer/ambulation technique		
6. Assisted in using commode/toilet in prescribed manner		
7. Positioned resident and equipment to assure safety and comfort of resident/call bell within reach		
8. Checked contents of commode/toilet for amount, color, consistency and abnormal characteristics		
9. Assisted resident to wash hands		
10. Cleaned commode and replaced equipment in designated area		
11. Used gloves/universal precautions as indicated		
12. Recorded/reported any pertinent observations of commode/toilet contents		
13. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when a resident is assisted to use the commode according to the procedure of the training program and the achievement indicators listed.

TASK:
Catheter Care

STANDARD:
The nurse aide will provide catheter care to promote personal hygiene and comfort and to decrease the risk of infection and inflammation in the resident who has an indwelling catheter.

TOOLS AND EQUIPMENT:

Disposable gloves	Bed protector	Bath blanket	Cotton balls
Antiseptic solution	Warm water	Basin	Clean washcloths and towel

PERFORMANCE GUIDE:

1. Wash hands
2. Identify resident and introduce self
3. Provide privacy
4. Explain procedure to resident
5. Put on disposable gloves
6. Position resident on his/her back, with legs separated and knees bent (if this is not possible, position resident on his/her side)
7. Protect bed linens with protective underpad
8. Remove top bed linens and cover resident with bath blanket
9. Fill basin with warm water. Use antiseptic solution or soap for cleansing
10. For the male resident:

    a. Gently draw foreskin back. Cleanse the glans from meatus toward shaft for approximately 4 inches. Use a fresh side of the washcloth for each stroke. Rinse and gently dry area

    For the female resident:

    a. Separate the labia. Cleanse from front to back using a fresh side of the washcloth with each stroke. Rinse and gently dry area

11. Inspect area and tubing for secretions. Remove secretions using a clean washcloth or antiseptic wipes if available

12. Clean and return equipment to proper storage areas

13. Remove gloves and wash hands

14. Report signs of irritation or complaints of discomfort

Student Name_____

TASK:

Catheter Care

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Washed hands before and after procedure		
2. Identified resident		
3. Provided for privacy		
4. Explained procedure		
5. Performed catheter care according to procedure		
6. Reported/recorded observations		
7. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the nurse aide provides catheter care to the resident according to performance guidelines.

TASK:
Urine/Stool Specimen Collection

STANDARD:
The nurse aide will collect routine urine and stool specimens utilizing Universal Precautions.

TOOLS AND EQUIPMENT:
Disposable gloves Tongue blades Toilet tissue Antiseptic gauze squares

Bedpan with cover or urinal Graduate pitcher specimen containers with lids

PERFORMANCE GUIDE:

1. Wash hands

2. Provide for privacy

3. Identify the resident and introduce self

4. Explain to the resident what is needed

5. Put on gloves

6. Routine Urine Specimen
   a. Have resident urinate into the clean bedpan or urinal
   b. Instruct the resident to <u>not</u> discard toilet tissue in the pan with the urine, and provide a plastic bag for this purpose
   c. After the resident has voided, offer a cleansing cloth
   d. Take the pan to the bathroom or utility room, measure if necessary, pour approximately 120 cc (4 oz.) into the specimen container
   e. Cover container tightly

7. Clean – Catch Urine Specimen
   a. Wash the resident's genital area properly or instruct the resident to do so.
      (1) For female residents:
         (a) Using the gauze or cotton and the antiseptic solution, cleanse the outer folds of the vulva (folds are also called labia or lips) with a front to back motion
         (b) Discard the gauze/cotton. Then cleanse the inner folds of the vulva with another piece of gauze and antiseptic solution, again with a front to back motion. Discard gauze/cotton
         (c) Finally, cleanse the middle, innermost area (meatus or urinary opening) in the same manner. Discard the gauze/cotton

(d) Keep the labia separated so that the folds do not fall back and cover the meatus

(2) For male patients:

(a) Using the gauze/cotton and the antiseptic solution, cleanse the tip of the penis from the urinary meatus down, using a circular motion. Discard gauze/cotton

b. Instruct the resident to void, allowing the first part of the urine to escape. Then:

(1) Catch the urine stream that follows in the sterile specimen container

(2) Allow the last portion of the urine stream to escape

Note: If the patient's I & O is being monitored, or if the amount of urine passed must be measured, catch the first and last part of the urine in a bedpan or urinal.

c. Place the sterile cap on the urine container immediately to prevent contamination of the urine specimen

d. Allow the resident to wash hands

e. With the cap securely tightened, was the outside of the specimen container

8. Stool Specimen
   a. Collect stool from daily bowel movement. Offer wash water to patient
   b. Use tongue blades to remove specimen, place in specimen container
   c. Cover container. Make sure cover is on tightly

9. Remove disposable gloves

10. Wash your hands

11. Take specimen to charge nurse or specimen holding area

12. Report that you have obtained the specimen and any observations you have made. Record the specimen on appropriate forms

Student Name_____

TASK:

Urine/Stool Specimen Collection

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Identified resident		
2. Washed hands before and after task		
3. Wore gloves for task, removed at appropriate time		
4. Explained procedure to resident		
5. Obtained required specimen according to guidelines		
6. Handled specimen container to maintain cleanliness		
7. Took specimen to appropriate person or area		
8. Reported and records task completion and observations		
9. Used appropriate physical and verbal contact		

CRITERIA:

Competence will be recognized when a urine/stool specimen is collected to insure accurate results and maintenance of asepsis.

TASK:
Proper Body Mechanics

STANDARD:
The nurse aide will use the appropriate muscles to perform the task in order to conserve energy and reduce injuries.

TOOLS AND EQUIPMENT:
None

PERFORMANCE GUIDE:

1. Has good standing posture:
   a. Feet flat on floor, 12 inches apart
   b. Arms at side
   c. Back straight
   d. Abdominal muscles tightened

2. Bend from the hips and knees, work close to the object

3. Use body weight to help push or pull the object rather than lift

4. Use the strongest muscles to do the job

5. Avoid twisting your body – PIVOT

6. Hold heavy objects close to the body

7. Get assistance if you feel the patient or object is too heavy

8. Use mechanical devices when necessary to move patients

Student Name_____

TASK:

Proper Body Mechanics

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Followed basic rules for proper body mechanics		
2. Sought assistance		
3. Used mechanical devices as appropriate		

CRITERIA:

Competency will be recognized when every effort is made to use good body mechanics in the provision of care.

TASK:
Ambulate Resident

STANDARD:
Resident's pulse, respiration and blood pressure should be taken before walking exercise begins. The nurse aide must steady the resident while the resident walks; one arm must be placed around resident's waist or a gait belt used. Tolerance of exercise and distance ambulated must be recorded/reported.

TOOLS AND EQUIPMENT:
Slippers/shoes Robe

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Wash hands
4. Assemble equipment at bedside
5. Provide privacy
6. Take resident's pulse, respiration and blood pressure if facility policy
7. Fanfold top bedding
8. Assist resident in putting on robe
9. Lock wheels of bed in place
10. Elevate head of bed
11. Assist resident to dangle if vital sign not taken, check pulse
12. Put shoes/slippers on resident
13. Put on gait belt
14. Assist resident to stand
15. Steady resident
16. Place arm around resident's waist if gait belt not used

17. Walk with resident keeping pace slow and walking close to wall
18. Return resident to bedside
19. Assist resident into bed
20. Assure resident comfort
21. Wash hands
22. Report/record tolerance of exercise

Student Name_____

TASK:

Ambulate Resident

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Assembled equipment		
4. Identified resident		
5. Explained procedure		
6. Ambulated resident in prescribed manner		
7. Positioned resident and equipment to assure comfort and safety		
8. Recorded/reported procedure and any pertinent observations		
9. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident ambulates according to the procedure of the training program and the achievement indicators listed.

TASK:
Transfer Techniques (Transfer Resident from Bed to Wheelchair)

STANDARD:
Resident will be transferred in a safe and comfortable manner with use of good body mechanics

TOOLS AND EQUIPMENT:
Wheelchair Bath blanket Transfer belt if needed

Appropriate clothing and shoes or robe and slippers

PERFORMANCE GUIDE:

1. Introduce self

2. Verify resident's identity and explain procedure

3. Wash hands

4. Provide privacy

5. Decide which side of the bed will be used. Move furniture to provide space

6. Place the chair or wheelchair at the head of the bed; the back must be even with the headboard

7. Place the pillow or folded bath blanket on the seat. Lock both wheels of the wheelchair and raise the footrests

8. Make sure the bed is in the lowest horizontal position and make sure that the wheels are locked

9. Fanfold top linens to the foot of the bed

10. Put the shoes on the resident

11. Help the resident to sit on the side of the bed. Make sure his or her feet touch the floor

12. Help the resident put on clothing or a robe

13. Apply the transfer belt

14. Assist the resident to a standing position. Use the following method if a transfer belt is used:

a. Stand in front of the resident
b. Ask the resident to place his or her hands on your shoulders
c. Grasp the transfer belt at each side with your hands
d. Brace your knees against the resident's knees and block his or her feet with your feet
e. Ask the resident to stand on the of "3". On the count of "3" pull the resident up into a standing position as you straighten your knees

15. If a transfer belt is not available, use the following method:
    a. Stand in front of the resident
    b. Place your hands under his or her arms. Your hands should be around the shoulder blades
    c. Ask the resident to push the fists into the mattress and lean forward on the count of "3"
    d. Brace your knees against the resident's knees and block his or her feet with your feet
    e. Pull the resident up into a standing position on the count of "3". You will straighten your knees as you pull the resident up

16. Support the resident in the standing position by holding the transfer belt or with your hands around the resident's shoulder blades. Continue to block the resident's feet and knees with your feet and knees. This helps prevent him or her from falling

17. Turn the resident so he or she can grasp the far arm of the chair. The legs will touch the edge of the chair. Continue to turn the resident until the other armrest is grasped

18. Lower him or her into the chair as you bend your hips and knees. The resident assists by leaning forward and bending the elbows and knees

19. Make sure the buttocks are to the back of the seat. Position the resident in good alignment

20. Position the feet on the footrests

21. Cover the resident's lap and legs with a lap robe or bath blanket. Make sure the blanket is off the floor and wheels

22. Remove the transfer belt if used

23. Position the chair as the resident prefers

24. Place the signal light and other necessary items within reach if the resident is going to stay at the bedside. Straighten the unit

25. Wash your hands

26. Report the following to the nurse:
    a. Pulse rate if taken before or after the transfer
    b. How well the resident tolerated the activity
    c. Complaints of lightheadedness, pain, discomfort, difficulty breathing, weakness, or fatigue
    d. The amount of assistance required to transfer the resident

27. Reverse the procedure to return the resident to bed.

Student Name_____

TASK:

Transfer Techniques (Transfer Resident from Bed to Wheelchair)

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Verified resident identity		
3. Explained procedure to resident		
4. Washed hands before and after procedure		
5. Provided privacy		
6. Locked wheels on wheelchair		
7. Supported and transferred resident in prescribed manner		
8. Used proper body mechanics		
9. Positioned resident for comfort and safety (call bell)		
10. Reported observations to nurse		
11. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident is transferred from bed to wheelchair according to the procedure of the training program and the achievement indicators listed.

TASK:
Position Resident in Bed

STANDARD:
Resident must be positioned in good body alignment

TOOLS AND EQUIPMENT:
Footboard Trochanter rolls Handrolls

PERFORMANCE GUIDE:

1. Introduce self
2. Verify resident's identity and explain procedure
3. Wash hands
4. Provide privacy
5. Place footboard at end of mattress
6. Position resident's feet flush against the footboard
7. Place feet in good alignment
8. Place loose end of rolled up bath blanket (trochanter roll) under resident from hip to knee
9. Tuck the roll along the side of the body to keep hips and knees in good alignment
10. Place handroll in resident's hand with thumb straightened out to prevent thumb contracture
11. Assure resident's comfort and safety (side rails and call bell)
12. Record all observations
13. Report observations/abnormalities to nurse

Student Name_____

TASK:

Position Resident in Bed

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Assembled equipment and supplies		
4. Identified resident and explained procedure		
5. Identified joints needing support		
6. Placed supports in prescribed manner		
7. Positioned resident and equipment to assure comfort and safety of resident – call bell with reach		
8. Recorded/reported procedure and pertinent observations		
9. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident is positioned and according to the procedure of the training program and the achievement indicators listed.

TASK:
Turn Resident in Bed

STANDARD:
One additional staff member must help in turning the bedridden resident. Side rails must be raised and pillows placed behind back and between knees. Skin condition must be examined and any reddened areas/pressure sores must be recorded on resident's chart and reported to nurse.

TOOLS AND EQUIPMENT:
Draw sheet Pillows Side rails Resident's chart

One additional staff member

PERFORMANCE GUIDE:

1. Check order/nursing care plan
2. Introduce self
3. Verify resident's identity and explain procedure
4. Wash hands
5. Assemble equipment
6. Lock bed wheels
7. Provide privacy
8. Lower side rails on near side
9. Position draw sheet under resident gently turning resident with help of staff member
10. Pull resident close to edge of bed
11. Turn resident, with help, to opposite side holding resident so the skin condition may be examined
12. Examine skin condition
13. Position pillows behind resident's back and between knees
14. Raise bed side rails

15. Assure resident comfort and safety (call bell)
16. Wash hands
17. Record procedure noting resident's skin condition on resident chart
18. Report any abnormalities to the nurse

Student Name_____

TASK:

Turn Resident in Bed

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Assembled supplies and equipment		
4. Identified resident and explained procedure		
5. Screened resident for privacy		
6. Positioned draw sheet under resident		
7. Positioned resident supporting joints/extremities of body to assure comfort and safety/call bell within reach		
8. Recorded/reported procedure and any pertinent observations		
9. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when a resident has been turned and positioned providing support and good body alignment according to the procedure of the training program and the achievement indicators listed.

TASK:
Mechanical Lift

STANDARD:
The nursing assistant will safely move a resident using a mechanical lift.

TOOLS AND EQUIPMENT:
Mechanical lift Additional staff Slings: solid, cut out

PERFORMANCE GUIDE:

1. Wash hands

2. Identify the resident and introduce self

3. Provide for privacy

4. Check equipment to be sure it is in good working order

5. Obtain assistance – minimum number for a safe transfer is two

6. Discuss the transfer with the resident. Realize that this is a frightening procedure for a dependent person

7. Use correct sling

8. Place the sling under the resident while he or she is in bed. The sling should be positioned with the top edge at the resident's shoulder. The bottom end should be at least mid-thigh. Be sure sling is straight and smooth under the resident

9. Bring lift to the bed

10. Roll the base, spread wide open under the bed

11. Secure the brakes on the lift

12. Lower the arm of the lift until you are able to attach the chains to the arm
    a. Keep the chains untangled and balanced
    b. The shorter chains are placed on the shoulder end and the longer to the lower end (Often the chains are marked for shoulder and/or hips)

13. Raise the sling just high enough to clear the bed. Have the second assistant help the resident's neck/head

14. Roll the lift slowly until the resident is positioned over the chair, stretcher, etc.
    a. Steady the sling with your hand

b. All comments should be made to reassure the resident of his/her safety

15. Slowly and steadily lower the lift until resident is positioned in chair

16. Disconnect chains, remove lift from area

17. Make sure resident is comfortable and safe before leaving
    a. Call bell is within reach
    b. An activity is provided if needed
    c. Privacy/dignity is provided

18. Reverse the steps to return the resident to bed

19. Wash hands

20. Report/record observations

Student Name_____

TASK:

Mechanical Lift

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Washed hands before and after procedure		
2. Explained procedure		
3. Demonstrated appropriate procedure for transfer using a mechanical lift		
4. Provided for resident psychological comfort and physical safety		
5. Used appropriate physical and verbal contact		

CRITERIA:

Competence will be recognized when a mechanical lift can be used to transfer a resident safely and with psychological comfort.

TASK:
Range of Motion

STANDARD:
Exercises must be repeated times three. Joints must be moved smoothly and slowly and all notable changes must be recorded on resident's chart

TOOLS AND EQUIPMENT:
Resident's chart

PERFORMANCE GUIDE:

1. Check nursing care plan
2. Introduce self
3. Verify resident's identity and explain procedure
4. Wash hands
5. Elevate bed to comfortable working height
6. Provide privacy
7. Position resident in supine position
8. Hold resident extremity to be exercised at joint
9. Flex and rotate joint smoothly and slowly through its ranges
10. Repeat range of motion times three for each joint

CAUTION: Do not use force and stop if resident experiences pain

11. Assure resident comfort and safety – call bell within reach
12. Wash hands
13. Report pain or notable changes in resident movement to nurse
14. Record care and changes or difficulties in resident's movement

Student Name_____

TASK:

Range of Motion

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Identified resident		
4. Explained purpose and procedure for range of motion		
5. Screened resident for privacy		
6. Moved resident's joints through range of motion three times in prescribed manner		
7. Supported each joint during movement		
8. Positioned resident to assure comfort and safety/call bell within reach		
9. Recorded/reported procedure and any pertinent observations		
10. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident's joints are moved through their range of motion according to the procedure of the training program and the achievement indicators listed.

TASK:
Walker Assistance

STANDARD:
Resident must be instructed on how to use walker; resident must be steadied during walking exercise. Tolerance of use of walker and distance walked must be recorded on resident's chart

TOOLS AND EQUIPMENT:
Resident's chart Walker Slippers/shoes, robe, or appropriate clothing

PERFORMANCE GUIDE:

1. Introduce self

2. Verify resident's identity and explain procedure

3. Wash hands

4. Assemble equipment and check for rubber tips on legs and hand grips
   a. Replace walker if necessary

5. Provide privacy

6. Assist resident to dangle

7. Assistant resident in putting on robe and slippers or appropriate clothing

8. Positioned walker at bedside

9. Lock wheels of bed

10. Assist resident to stand (use proper technique and body mechanics)

11. Position walker around resident

12. Instruct resident to grasp hand bar keeping elbows flexed

13. Adjust height of walker so that hand bar is just below resident's waist

14. Instruct resident on how to use walker
    a. For resident with two weak legs:
       (1) move walker ahead 6 inches
       (2) move right foot up to walker
       (3) move left foot up to right foot
    b. For resident with one weak leg:

(1) move walker and weak leg ahead 6 inches at same time
(2) move stronger leg ahead

15. Steady resident as resident proceeds to walk

16. Walk close behind and slightly to side of resident

17. Assist resident back to bed

18. Assist resident to remove robe and slippers (if appropriate)

19. Assure resident comfort and safety – call bell within reach

20. Position walker within resident's reach as condition dictates

21. Wash hands

22. Report/record resident tolerance of use of walker

Student Name_____

TASK:

Walker Assistance

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Introduced self		
2. Washed hands before and after procedure		
3. Assembled supplies and equipment		
4. Identified resident		
5. Explained procedure		
6. Moved resident from bed in prescribed manner using proper body mechanics		
7. Instructed resident on how to use walker		
8. Positioned resident and equipment to assure comfort and safety – call bell within reach		
9. Recorded/reported procedure and any pertinent observations		
10. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident is assisted to use the walker according to the procedure of the training program and the achievement indicators listed

TASK:
Cane Assistance

STANDARD:
The nurse aide will provide necessary assistance for safe use of a cane by the resident who needs support and balance

TOOLS AND EQUIPMENT:
Variety of canes

PERFORMANCE GUIDE:

1. Wash hands before and after procedure
2. Verify cane use with charge nurse and/or physical therapy person
3. Check cane for rubber tips
4. Check pathways for items that could cause falls
5. Check height of cane for correct fit
6. Position cane on side of stronger leg
7. Instruct resident in appropriate use of cane – check care plan
8. Monitor resident for steadiness
9. Report/record observations

Student Name_____

TASK:

Cane Assistance

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Assisted with cane use to ensure resident safety		
2. Identified correct size/fit of cane		
3. Recorded/reported observations		
4. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident is provided with safe cane assistance

TASK:
Wheelchair Assistance

STANDARD:
The nurse aide will provide safe wheelchair assistance

TOOLS AND EQUIPMENT:
Variety of styles of wheelchairs

PERFORMANCE GUIDE:

1. Wash your hands

2. Identify the resident and introduce self

3. Provide for privacy

4. Position the wheelchair appropriately

5. Lock the brakes and raise the footrests

6. Follow the procedure for assisting a resident into a wheelchair

7. Maintain proper body position by:
   a. Positioning hips well back in the chair
   b. Positioning feet on the footrests
   c. Making sure the trunk of the body is balanced
   d. Use of support devices to prevent sliding
   e. Use of armrests or pillows for arm comfort

8. Provide a covering for the resident's lap, if needed

9. Unlock the wheels of the chair

10. If assistance is needed, guide the chair from behind:
    a. Stay to the right of hallways
    b. Be careful when approaching intersecting hallways
    c. Back down slanted ramps
    d. Back into and out of elevators and doors

11. Consider nasogastric tubes, catheters and tubing, dressings and braces, avoid pulling or dislodging

12. Dependent residents should be repositioned every 1 to 2 hours while in the wheelchair and not be up longer than 3 hours without a rest period in bed

13. Report/record observations

Student Name_____

TASK:

Wheelchair Assistance

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Correctly positioned wheelchair		
2. Maintained correct body alignment/position		
3. Provided for dignity/privacy		
4. Correctly maneuvered the wheelchair		
5. Took care not to dislodge tubes, dressings, and braces		
6. Provided for repositioning and rest at appropriate times		
7. Washed hands before and after procedure		
8. Used appropriate physical and verbal contact		

CRITERIA:

Competence in the task will be recognized when the resident is provided with safe wheelchair assistance

TASK:
Postmortem Care

STANDARD:
The nurse aide will provide care after death with respect and dignity for the body

TOOLS AND EQUIPMENT:

Shroud/clean sheet	Identification tag	Basin	Soap and water
Pads as needed	Washcloth and towel	Gloves	Cotton
Bandages			

PERFORMANCE GUIDE:

1. Wash hands

2. Provide privacy

3. Check resident identification

4. Put on disposable gloves

5. Have the nurse remove appliances, tubing, etc.

6. Work quickly and quietly; maintain an attitude of respect. If it is necessary to speak, do so only in relation to the procedure

7. Place the body on the back with head and shoulders elevated on a pillow
   a. Close the eyes. Place a moistened cotton ball on each eye if the lids do not remain shut
   b. Replace dentures in the patient's mouth
   c. The jaw or hands may needs to be secured with light bandaging. Tight bandaging or undue pressure from the hands may leave marks so handle the body gently. Pad beneath the bandage

8. Bathe as necessary. Remove any soiled dressings and replace with clean ones. Groom hair

9. Pad between the ankles and knees with cotton. Tie lightly

10. Place a pad underneath the buttocks. If the family is to view the body:
    a. Put a clean gown on the patient
    b. Cover the body to the shoulders with a sheet
    c. Make sure the room is neat and tidy
    d. Adjust the lights to a subdued level

e. Allow the family to visit in private

11. Put the shroud on the patient after the family leaves if facility policy

12. Collect all belongings and make a list

13. Fill out the identification cards and fasten if facility policy:
    a. One card on the resident's right ankle or right big toe
    b. One card on the resident's clothing and valuables (securely wrapped)

14. Wash hands

15. Report completion of the task and care of belongings

Student Name_____

TASK:

Postmortem Care

ACHIEVEMENT INDICATORS: The Trainee:	Yes	No
1. Washed hands before and after procedure		
2. Demonstrated the procedure for postmortem care		
3. Recognized the need for dignity and respect while caring for the body		

CRITERIA:

Competency will be recognized when postmortem care is provided with respect and dignity

SOURCES/BIBLIOGRAPHY
FOR CLINICAL SKILLS

The Performance Guides and Achievement Indicators for each clinical skill were derived from the following sources:

Hoeman, S.; Glenn, N. and Stymacks, A. (1990), Rehabilitation/Restorative Care in the Community. St. Louis: C.V. Mosby Company.

Hogan, J. and Sorrentino, S. (1988) Textbook for Long-Term Care Assistants. St. Louis: C.V. Mosby Company.

Michigan Nurse Aide Training Curriculum, 1989

Witmer, Dorothy M. (1990) Geriatric Nursing Assistant: Advanced Training in Selected Competencies. New Jersey: Prentice – Hall, Inc.

Unit 1: THE LONG-TERM CARE FACILITY

Classroom: 1.0
Lab:
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Describe three basic purposes of long-term care facilities	1. Purposes: a. to provide care based on identified needs such as rehabilitative care, personal care, services, etc. b. to provide services by a multidisciplinary team c. to promote function and independence	Class: Lecture/ Discussion	Exam/Quizzes: 75% accuracy on written/oral examination
2. Name two types of long term facilities	2. a. Nursing Home/County Medical Care Facility b. Hospital Long Term Care Unit		
3. Identify a major legal responsibility of the long term care facility	3. OVERVIEW OF CONCEPT OF RESIDENT RIGHTS	Handout: Facility Bill of Rights	
4. Give two examples of ethical issues faced by long term care facilities	4. a. Artificial feeding b. Do not resuscitate c. Living Wills		
5. Describe the basic organizational structure of a long care facility	5. Organizational Chart	Class: Lecture/Discussion	

Unit 1: THE LONG-TERM CARE FACILITY

Classroom: 1.0
Lab:
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
6. Describe the roles and relationships of workers in a long term care facility	6. Organizational Chart and brief job description: a. Administrator b. Director of Nursing (DON) c. Medical Director d. Charge Nurse e. Nurse aide f. Other (Physical Therapist/Occupational Therapist, Dietician, etc.)	Handouts: Organizational structure of long term care facility Brief job description of Director of Nursing, Charge Nurse, Administrator, and nurse aide	
7. Give examples of standards for long term care facilities	7. Overview of regulations a. Medicare, Medicaid certification b. Role of regulatory agencies (Michigan Department of Public Health, etc.)		

Unit 2. THE LONG TERM CARE RESIDENT

Classroom: 1.0
Lab:
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Describe common physical changes of aging and their impact on function	1. Aging process/concept of functional impairment: vision, hearing, mobility	Class: Lecture/discussion	Exams/Quizzes: 75% accuracy on written/oral examination
2. Describe major life changes and losses experienced by residents of long term care facilities	2. Transitions and losses: a. relocation b. bereavement c. loss of health, independence, social support		
3. Describe common chronic illnesses of the long term care resident	3. Basic definitions of: a. Diabetes b. Parkinson's Disease c. Dementia d. Degenerative Joint Disease e. Hypertension f. Chronic Obstructive Pulmonary Disease g. Congestive Heart Failure h. Stroke	Handout: Basic definitions of common chronic illness	
4. Describe ways to meet long term care residents' psycho-social needs	4. Strategies and nurse aide role: a. Identify residents' individual needs and wishes b. Promote social interaction c. Promote involvement in activities	Class: Lecture/Discussion	

Unit 2. THE LONG TERM CARE RESIDENT

Classroom: 1.0
Lab:
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
5. Identify the role of family members or significant others in identification of the resident's needs and development of care plan	5. a. Role of the care conference b. Involvement of resident/family/significant other in: 1) needs identification 2) care planning		
6. Discuss cultural and religious differences that may influence values and preferences	6. A. Ethnic/Racial groups: 1) Caucasian 2) Black-American 3) Hispanic 4) Asian 5) American Indian 6) Other b. Religious: 1) Protestant 2) Judaism 3) Catholic 4) Other		

Unit 3: Resident Rights

Classroom: 2.0
Lab:
Clinical:
Total: 2.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO: 1. Describe the rights of the resident as specified in the Michigan Public Health Code	1. Michigan Public Health Code Sections: 333.20201 333.21771 a. Privacy and confidentiality b. Personal Choices c. Resolution of Grievances - function of the Resident Council d. Sexuality and expression of sexual needs e. Care and Security of Personal Possessions f. Minimization of use of physical and chemical restraints - see Unit 11 on restraints g. Other	Class: Lecture/Discussion Case Examples Handouts: 1. Michigan Public Health Code Sections 333.20201 and 333.21771 2. Omnibus Budget Reconciliation Act of 1987 (OBRA) Public Law 100-203	Exams/Quizzes: 75% accuracy on written/oral examination
2. Explain ways that the nurse aide can promote/protect resident rights	2. Strategies related to rights identified in objective #1		
3. Define and give an example of: a. Abuse b. Neglect c. Exploitation d. Endangerment	3. Definitions and examples of abuse, neglect, exploitation, and endangerment as stated in Identification and Reporting of Abuse: A Training Manual for Nursing Home Aides, Michigan Department of Public Health, 1988, pp. 3-6		

Unit 3: Resident Rights

Classroom: 2.0
Lab:
Clinical:
Total: 2.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
4. Identify common situations that may cause abuse, neglect, endangerment, or exploitation	4. Common causes of abuse, neglect, endangerment, and exploitation stated in Identification and Reporting of Abuse: A Training Manual for Nursing Home Aides p. 7	Reading Assignments: Identification and Reporting of Abuse: A Training Manual for Nursing Home Aides - Student Section pp. 6-13; 14-21	
5. Explain the procedure and requirements for reporting abuse	5. Process and requirements for: a. Who must report b. To whom reports must be made c. Penalties incurred for failure to report		
6. Describe the nurse aide's responsibilities in an investigation of abuse	6. Process of investigating abuse and nurse aide responsibilities in investigation after a report is filed. Identification and Reporting of Abuse: A Training Manual for Nursing Home Aides p.13	Reading Assignment: Identification and Reporting of Abuse: A Training Manual for Nursing Home Aides - Student Section pp. 23-26	
7. Identify penalties incurred for substantiated claims of abuse/neglect	7. Penalties for: a. Facility b. Perpetrator	Reading Assignment: Identification and Reporting of Abuse: A Training Manual for Nursing Home Aides - Student Section p. 27	

Unit 4: The Nurse Aide as a Member of the Health Care Team

Classroom: 2.0
Lab:
Clinical:
Total: 2.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Describe the role and responsibility of the nurse aide in a long term care facility	1. a. Observation, reporting, recording changes in resident's condition b. Personal care services c. Assistance with activities of daily living d. Assist residents in attaining and maintaining functional independence e. Communicate and interact in a sensitive manner with residents f. Support and Promote Residents Rights g. Other	Class: Lecture/Discussion	Exams/Quizzes: 75% accuracy on written examination
2. Identify ethical behaviors of the nurse aide	2. a. Definition of ethics/ethical behavior b. Examples of ethical behavior c. Examples of unethical behavior (accepting tips and gifts, eating resident's food, etc.)		
3. Explain legal responsibilities of the nurse aide	3. Functions that can and cannot legally be performed by a nurse aide a. Scope of job description b. Performance of tasks for which competency has been demonstrated c. Support resident rights	Handout: Michigan Public Health Code Section 333.20201	

Unit 4: The Nurse Aide as a Member of the Health Care Team

Classroom: 2.0
Lab:
Clinical:
Total: 2.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
4. Discuss qualities of an effective nurse aide	4. a. Hygiene b. Health (nutrition, stress management, exercises, etc.) c. Professional appearance d. Attitude	Handout: - Facility job descriptions (NA, LPN, RN) - worksheets - Sample care plan	
5. Describe the roles of the nurse aide, Licensed Practical Nurse (LNP) and Registered Nurse (RN) in the planning and provision of resident care.	5. a. Purpose and use of resident care plan b. Delegation of duties c. Channels for reporting and recording d. Planning and organizing work (sequencing and prioritizing tasks)	Handout: - Facility job descriptions (NA, LPN, RN) - worksheets - Sample care plan	

Unit 5: Human Interaction Skills

Classroom: 2.0
Lab:
Clinical:
Total: 2.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Identify elements necessary for effective communication	1. a. Definition of communication (verbal and non-verbal) b. Concise c. Clear - words have same meaning for all parties d. Logical e. Communication that facilitates dignity and respect of individual 1) sensitivity/impact of values 2) attitudes	Class: Lecture/Discussion	Exams/Quizzes: 75% accuracy on written/oral examination
2. Describe four (4) ways to facilitate communication with residents in long term care	2. a. Body language (social expression, gestures, etc) b. Active listening skills c. Use of touch d. Modification of nurse aide's behavior in response to resident's needs e. Reinforcement techniques (praise, etc)	Role playing Show magazine pictures depicting variety of emotion/body language Group discussion of interpretation	

Unit 5: Human Interaction Skills

Classroom: 2.0
Lab:
Clinical:
Total: 2.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
3. Identify communication strategies to assist residents who have special needs	3. A. Visually impaired resident b. Hearing impaired resident c. Cognitively impaired resident d. Aphasia and dysarthria e. Other (language barrier, behavior problems) f. See Unit 11 on Restraints	Role playing Simulate vision and hearing impairment among students Picture boards Care and maintenance of hearing aides (guest speaker) Care and maintenance of eye glasses/contact lenses (guest speaker)	
4. Discuss strategies to resolve conflicts between: a. residents b. staff c. residents and staff	4. a. Basic conflict resolution strategies b. Resident Council c. Employer/employee grievance procedure d. Facility policy e. Resident grievance procedure	Role playing	

Unit 6: Infection Control

Classroom: 2.0
Lab: 2.0
Clinical:
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Define Infection	1. a. Concept of immune system (antibodies) b. Disease state - invasion and growth of microorganisms 1) Local 2) Systemic	Class: Lecture/Discussion	Exams/Quizzes: 75% accuracy on written/oral examination
2. Identify common causes of infection	2. Definition and types of pathogens a. Bacteria b. Virus c. Other		
3. Describe ways that infection is spread among nursing home residents	3. a. Portals of entry for microorganisms 1) Respiratory (inhale) 2) Gastro-intestinal (ingest) 3) Blood 4) Breaks in skin b. Portals of exit for mircoorganisms 1) Respiratory (airborne droplets - coughing, sneezing) 2) Gastro-intestinal (urine, feces) 3) Blood 4) Wound drainage c. Methods of spreading microorganisms 1) Hands 2) Food, fluids 3) Dressings 4) Contaminated equipment/utensils 5) Insects 6) Animals	See attached for suggested teaching methodologies	

Unit 6: Infection Control

Classroom: 2.0
Lab: 2.0
Clinical:
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
4. Name the most common infectious organisms found in nursing home residents	4. a. Staphylococcus b. Streptococcus c. Infestation (scabies) d. Other		
5. Identify requirements needed for the growth of microorganisms	5. a. Host/reservoir b. Moisture c. Warmth d. Darkness e. Nourishment f. Oxygen (Differentiate between aerobic and anaerobic)		
6. Explain why elderly people are susceptible to infection	6. a. Aging process/compromised immune system b. Common problems that predispose residents to infection 1) Chronic illness (diabetes) 2) Poor nutrition 3) dehydration 4) Stress/fatigue		

Unit 6: Infection Control

Classroom: 2.0
Lab: 2.0
Clinical:
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
7. Identify common signs and symptoms of infection	7. A. Classic signs and symptoms 1) Systemic a) Fever b) Anorexia c) Fatigue/lethargy 2) Local a) Erythema b) Purulent drainage c) Pain, tenderness, swelling B. Altered presentation of infection in nursing home residents 1) May have absence of (or very mild) classic systemic signs and symptoms 2) Confusion/agitation 3) Change in physiological functions and activities of daily living		
8. Discuss the nurse aide's responsibility in reporting and recording observations of the resident who has an infection	8. a. Timeliness b. Written/oral reporting and recording c. Chain of command		

Unit 6: Infection Control

Classroom: 2.0
Lab: 2.0
Clinical:
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
9. Describe ways to prevent and control infection in the nursing home resident and health care worker	9. A. Definition of medical asepsis: prevent the spread of microorganisms through practices, which ensure cleanliness of hands and appropriate care and handling of equipment, food, etc. b. Examples of aseptic technique 1) Handwashing 2) Universal precautions 3) Isolation 4) Chemical disinfection 5) Appropriate handling of equipment, linen, food, waste products, body fluids c. Employee health 1) Employees who are ill or infected should not care for residents 2) Importance of reporting (self or family), breaks in skin, etc. 3) Health promotion practices	Guest Speaker/Resources: Local/State Health Department Local Hospital Medical supplier Center for Disease Control American Red Cross	
10. Define Universal Precautions	10. Facility policy based on broad or narrow definition per Center for Disease Control guidelines		
11. Give examples of the appropriate use of Universal Precautions	11. Definition per facility policy		
12. Demonstrate Universal Precautions	12. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedure for the training program

Unit 6: Infection Control

Classroom: 2.0
Lab: 2.0
Clinical:
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
13. Demonstrate handwashing	13. Facility policy/procedure or see Appendix A	Demonstration/Return demonstration	
14. Demonstrate isolation technique	14. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	

Unit 7: Safety/Emergency Procedures

Classroom: 2.0
Lab: 2.0
Clinical:
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Identify common emergency situations which occur in a nursing home	1. A. Resident situations 1) Falls 2) Respiratory emergencies (choking, aspiration, airway obstruction) 3) Cardiac arrest 4) Seizures 5) Loss of consciousness 6) Burns 7) Laceration/Bleeding B. Facility situations 1) Fire 2) Power failure 3) Severe weather 4) Other	Class: Lecture/Discussion	Exams/Quizzes: 75% accuracy on written/oral examination
2. Identify common causes of resident falls	2. a. Knee joint instability b. Medication side effects (dizziness, drowsiness, etc.) c. Low blood pressure/postural hypotension d. Impaired coordination e. Visual impairment f. Cognitive impairment (poor judgment, misperception, etc) g. Environmental hazards (clutter, etc)		

Unit 7: Safety/Emergency Procedures

Classroom: 2.0
Lab: 2.0
Clinical:
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
3. Describe three ways to prevent falls in a nursing home resident	3. a. Assistance with ambulation b. Appropriate assistance/supervision c. Environment free of clutter d. Slow rising from bed/chair e. See Unit 11 or Restraints		
4. Demonstrate the appropriate response/action for a nurse aide when a resident falls	4. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedure for the training program
5. Identify common causes for respiratory emergencies in the nursing home resident	5. a. Diseases b. Improper feeding technique c. Inadequate supervision while eating d. Improper position while eating		
6. List three ways to prevent respiratory emergencies in the nursing home resident	6. a. Proper feeding technique b. Appropriate supervision during mealtime c. Proper positioning for eating		
7. Describe the appropriate nurse aide response/action for a resident in respiratory distress/arrest	7. a. Recognition of signs of respiratory distress/arrest b. Action per facility policy	Resource: American Red Cross	

Unit 7: Safety/Emergency Procedures

Classroom: 2.0
Lab: 2.0
Clinical:
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
8. Demonstrate the Heimlich Maneuver	8. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	
9. Identify the signs of cardiac arrest*	9. Signs of cardiac arrest		

*If the nurse aide trainee is expected to be competent in CPR (BCLS) - this must be taught in addition to the minimum 75 hour training program

10. Describe the appropriate nurse aide response/action when a resident is in cardiac arrest	10. Facility policy/procedure or see Appendix A		
11. Demonstrate the nurse aide's appropriate action for a resident experiencing a seizure	11. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	
12. List common reasons why a resident may lose consciousness	12. a. Hypoglycemia/hyperglycemia b. Transient ischemic attacks c. Low blood pressure d. Other		
13. Demonstrate the appropriate nurse aide response/action for the unconscious resident	13. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	

Unit 7: Safety/Emergency Procedures

Classroom: 2.0
Lab: 2.0
Clinical:
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
14. Identify common causes for burns in the nursing home resident	14. a. Unsupervised smoking b. Contact with hot objects/liquids 1) Bath water 2) Hot packs and heating pads 3) Food/beverages (spills, ingestion) 4) Metal near heat source/heater c. Electrical hazards		
15. Describe ways to prevent burns in a nursing home resident	15. a. Adequate supervision b. Monitoring/testing temperature of food and beverages c. Monitoring of environment (heat source, electrical hazards, etc)		
16. Demonstrate the appropriate action/response for a nurse aide when a resident is burned	16. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	
17. Identify common causes for bleeding/lacerations in the nursing home resident	17. a. Skin tears due to repositioning or transfer b. Falls c. Other		
18. Describe ways to prevent bleeding/lacerations in the nursing home resident	18. a. Care with resident while transferring, repositioning (consideration of skin fragility) b. Prevention of falls (see objective #3)		

Unit 7: Safety/Emergency Procedures

Classroom: 2.0
Lab: 2.0
Clinical:
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
19. Demonstrate the appropriate nurse aide action/response for the resident who is bleeding	19. a. Facility policy/procedure or see Appendix A b. Universal Precautions (see objective #10 - Unit on Infection Control)	Demonstration/Return Demonstration	
20. Describe safety practices to prevent fires in the nursing home.	20. a. Supervised smoking b. Fire code/regulations per State Fire Marshal	Resource: State Fire Marshal Rules 1991	
21. Demonstrate the appropriate action/response of a nurse aide if a fire occurs in the nursing home	21. Facility policy/procedure a. Resident Safety Procedure b. Fire extinguisher usage	Demonstration/Return Demonstration	
22. Describe the appropriate action for the nurse aide during severe weather	22. Facility policy/procedure		
23. Describe the appropriate action for the nurse aide during a power failure	23. Facility policy/procedure		

Unit 8A: Basic Personal Care Skills

8A Introduction

Classroom: .5
Lab:
Clinical: 6.0
Total: 6.5*

*Clinical hours for entire Unit 8A-8H

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Describe factors, which ensure the comfort, dignity, safety, cleanliness, and independence of the resident in the provision of personal care.	1. a. Knowledge, attitude, skills of staff b. Understanding of basic human needs c. Resident's Rights d. Importance of nurse aide's role: aide's knowledge of resident nurse aide as primary provider of personal care	Class: Lecture/Discussion	Exams/Quizzes: 75% accuracy on written/oral examination
2. Give three reasons why personal care is essential to a long term care resident	2. a. Basic human needs - comfort b. Resident's Rights c. Prevention of problems/poor outcomes	Resource: Maslow's Hierarchy of Needs	
3. Explain the components of personal care	3. a. Oral hygiene b. Skin care c. Perineal care d. Foot care e. Nail care f. Dressing g. Grooming h. Bathing		
4. Demonstrate basic personal care skills	4. (See individual units)		

Unit 8A: Basic Personal Care Skills

Classroom: .5
Lab:

8A Introduction

Clinical: 6.0
Total: 6.5*

*Clinical hours for entire Unit 8A-8H

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
5. Identify observations the nurse aide should make during the provision of personal care	5. a. Physical changes b. Behavioral changes c. Resident's concerns		
6. Discuss the nurse aide's responsibility in reporting and recording observations noted during the provision of personal care	6. A. Characteristics of observations: 1) Accuracy 2) Timeliness 3) Objectivity B. Types of observations 1) Resident 2) Environment a) Safety b) Equipment C. Written/oral reporting and recording D. Chain of command		

Unit 8B: Oral Hygiene

Classroom: 1.0
Lab: .5
Clinical:
Total: 1.5

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Define oral hygiene	1. Definition: cleanliness and comfort of the oral cavity (mucous membranes, tongue, teeth/dentures); care of the mouth and teeth using techniques such as brushing, flossing, mouthwash, etc., as appropriate	Class: Lecture/Discussion	Exams/Quizzes: 75% accuracy on written/oral examination
2. Discuss the importance and frequency of oral hygiene	2. Effects of oral hygiene on: a. Comfort b. Prevention of problems c. Appetite d. Socialization		
3. Identify the levels of assistance required for oral hygiene	3. a. Non-assisted b. Partially assisted c. Totally assisted	Guest Speaker: Dentist or Dental Hygienist to demonstrate techniques for oral hygiene	
4. Identify safety precautions for the nurse aide providing oral hygiene	4. a. Universal Precautions b. Protection from biting, combativeness, etc		

Unit 8B: Oral Hygiene

Classroom: 1.0
Lab: .5
Clinical:
Total: 1.5

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
5. Demonstrate oral hygiene for the resident with natural teeth	5. a. Facility policy/procedure or see Appendix A b. Non-assisted c. Partially assisted d. Totally assisted 1) Comatose resident 2) Paralyzed resident e. Care and proper storage of equipment/toothbrush	Demonstration/Return Demonstration	Competence in the task will be recognized when a student performs it according to the procedures for the training program
6. Demonstrate oral hygiene for the resident with dentures	6. a. Facility policy/procedure or see Appendix A b. Non-assisted c. Partially assisted d. Totally assisted	Demonstration/Return Demonstration	
7. Identify special precautions used in the care of dentures	7. a. Solutions b. Care and proper storage of equipment/dentures c. Safe handling (nurse aide and resident) d. Removal and insertion e. Identification f. Inspection for damage and fit		

Unit 8B: Oral Hygiene

Classroom: 1.0
Lab: .5
Clinical:
Total: 1.5

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
8. Demonstrate oral hygiene for the resident without teeth or dentures	8. a. Facility policy/procedure or see Appendix A b. Non-assisted c. Partially assisted d. Totally assisted e. Care and proper storage of equipment	Demonstration/Return Demonstration	
9. Demonstrate oral hygiene for the resident with special needs	9. A. Facility policy/procedure or see Appendix A b. Feeding tube c. Other (recent tooth extractions, cancer of tongue, tracheotomy, difficulty swallowing) d. Care of proper storage of equipment	Demonstration/Return Demonstration	
10. Discuss the nurse aide's responsibility in reporting and recording observations noted during the provision of oral hygiene	10. a. Type of observations 1) Inspection 2) Resident's concerns b. Types of observations to report c. Written/oral reporting and recording		

Unit 8C: Skin Care

Classroom: 1.0
Lab:
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Describe skin changes that occur with aging	1. a. Dryness b. Itching c. Fragility d. Decreased subcutaneous fat/"padding"	Class: Lecture/Discussion	Exams/Quizzes: 75% accuracy on written/oral examination
2. Explain the importance of skin care	2. a. Comfort b. Prevention of problems c. Maintenance of health skin		
3. Identify skin care needs	3. a. Cleanliness b. Lubrication c. Protection		
4. Identify methods to maintain healthy skin	4. a. Cleanliness 1) Frequency 2) Consideration of problems such as incontinence b. Lubrication 1) Types 2) Frequency c. Protection d. Nutrition/hydration e. Maintenance of circulation		

Unit 8C: Skin Care

Classroom: 1.0
Lab:
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
5. Demonstrate techniques for proper skin care	5. a. Facility policy/procedure or see Appendix A b. Massage c. Cleanliness d. Lubrication e. Protection	Demonstration/Return Demonstration	Competence for the task will be recognized when a student performs if according to the procedure for the training program
6. Discuss the nurse aide's responsibility in recording and reporting observations noted during the provision of skin care	6. a. Types of observations 1) Inspection 2) Resident's concerns b. Types of observations to report c. Written/oral reporting and recording		
7. Identify conditions that predispose a resident to skin problems	7. a. Incontinence b. Immobility/weakness/paralysis c. Circulatory impairment d. Diabetes e. Dehydration/malnutrition f. Gait instability/falls g. Decreased sensation h. Age-related changes i. Other		

Unit 8D: Hand and Foot Care

Classroom: .5
Lab: .5
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Describe the importance of hand and fingernail care for the nursing home resident	1. a. Comfort b. Hygiene c. Resident Rights	Class: Lecture/Discussion	Exams/Quizzes: 75% accuracy on written/oral examination
2. Identify observations the nurse aide should make during hand and fingernail care	2. a. Physical changes 1) Contracture 2) Thickened nails 3) Color of skin and nails 4) Hangnails b. Resident concerns	Guest Speaker: Beautician/manicurist to demonstrate nail care	
3. Discuss the nurse aide's responsibility in reporting and recording observations noted during hand and fingernail care	3. a. Timeliness b. Written/oral reporting and recording c. Chain of command		
4. Demonstrate cleaning, filing and trimming of resident's fingernails	4. a. Facility policy/procedure b. Nail care as a routine part of bathing	Demonstration/Return Demonstration	Competence in the task will be recognized when a student performs it according to procedures for the training program

Unit 8D: Hand and Foot Care

Classroom: .5
Lab: .5
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
5. Discuss the importance of foot and toenail care for the nursing home resident	5. a. Definition of foot care as the provision of: 1) Comfort 2) Hygiene b. Resident Rights c. Prevention of problems/maintenance of mobility d. Nurse aide performs toenail care/trimming if included in facility policy		
6. Identify observations the nurse aide should make during foot care	6. a. Physical changes 1) Thickness of nails 2) Color of skin and nails 3) Skin temperature 4) Abnormalities a) Ingrown toenail b) Fungal infection c) Corns, calluses, bunions d) Swelling/edema e) Lesions/ulcer f) Other b. Resident concerns	Guest Speaker: Geriatric Nurse Practitioner or Podiatrist	
7. Discuss the nurse aide's responsibility in reporting and recording observations noted during the provision of foot care	7. a. Timeliness b. Written/oral reporting and recording c. Chain of command d. Nurse aide as primary observer of resident's feet/nails		

Unit 8D: Hand and Foot Care

Classroom: .5
Lab: .5
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
8. Identify risk factors and problems that may require a nurse or a podiatrist to perform foot and toenail care	8. a. Diabetes b. Peripheral vascular disease c. Edema d. Excessively thick nails e. Abnormalities listed in # 6 f. Structural abnormalities (hammer toes, etd.) g. Other		
9. Give examples of problems and consequences that may result from toenail care or neglected nails	9. a. Examples of problems 1) Nails too short/too long 2) Inappropriate angle of trim 3) Nicks/cuts b. Consequences 1) Pain/immobility 2) Infection	Guest Speaker: Podiatrist to demonstrate routine foot care	
10. Identify the importance of proper fit of shoes, socks, and slippers	10. a. Safety b. Comfort c. Prevention of problems such as corns, blisters d. Importance of inspecting footwear for fit, wear, structure, foreign objects		
11. Demonstrate foot care	11. a. Facility policy/procedure or see Appendix A b. Foot care as routine part of bath	Demonstration/Return Demonstration	

Unit 8E: Hair Care and Shaving

Classroom: .5
Lab: 1.5
Clinical:
Total: 2.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Discuss the importance of hair care and shaving	1. a. Comfort b. Hygiene c. Resident Rights	Class: Lecture/Discussion	Exams/Quizzes: 75% accuracy on written/oral examination
2. Identify observations the nurse aide should make during hair care and shaving	2. a. Physical characteristics 1) Changes 2) Lesions 3) Abnormal hair loss 4) Condition of scalp b. Resident's concerns	Guest Speaker: Beautician	
3. Discuss the nurse aide's responsibility in reporting and recording observations noted during the provision of hair care and shaving	3. a. Timeliness b. Written/oral reporting and recording c. Chain of command		

Unit 8E: Hair Care and Shaving

Classroom: .5
Lab: 1.5
Clinical:
Total: 2.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
4. Demonstrate hair care for a male and female using the appropriate level of assistance	4. a. Facility policy/procedure or see Appendix A b. Female 1) Resident preference a) Shampooing b) Styling - techniques for brushing, combing, appropriateness of style c) Ethnic/cultural considerations d. Appropriate use of beautician 2) Care of comb and brush a) Identification b) Cleaning/storage c. Male 1) Resident preference a) Shampooing b) Styling - brushing and combing c) Ethnic/cultural considerations d) Appropriate use of barber 2) Care of comb and brush a) Identification b) Cleaning/storage	Demonstration/Return Demonstration Guest Speaker: Barber or beautician	Competence in the task will be recognized when the student performs it according to the procedure for the training program

Unit 8E: Hair Care and Shaving

Classroom: .5
Lab: 1.5
Clinical:
Total: 2.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
5. Demonstrate shaving the male resident using the appropriate level of assistance	5. a. Facility policy/procedure or see Appendix A b. Types of razors 1) Electric 2) Safety razor c. Safety precautions d. Frequency e. Resident preferences f. Care of Equipment 1) Identification 2) Cleaning and storage 3) Proper disposal of safety razor	Demonstration/Return Demonstration	
6. Demonstrate shaving/hair removal for a female resident using the appropriate level of assistance	6. a. Facility policy/procedure or see Appendix A b. Facial hair 1) Shaving 2) Tweezing 3) Resident preferences c. Leg and axillary hair 1) Shaving 2) Resident preference	Demonstration/Return Demonstration Simulate shaving using a balloon or inflated disposable glove	

Unit 8F: Perineal Care

Classroom: .5
Lab: 1.0
Clinical:
Total: 1.5

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Define perineal care.	1. Identify perineal area/perineum	Class: Lecture/Discussion	Exams/Quizzes: 75% accuracy on written/oral examination
2. Discuss the importance of perineal care.	2. a. Comfort b. Hygiene c. Resident Rights d. Prevention of problems 1) Infection in uncircumcised male 2) Vaginitis		
3. Identify observations the nurse aide should make during the provision of perineal care.	3. a. Physical characteristics 1) Lesions 2) Drainage/discharge 3) Odor 4) Cysts, abscesses, lumps, bruises 5) Other abnormalities b. Resident concerns (pain, itching, burning)		
4. Discuss the nurse aide's responsibility in reporting and recording observations made during the provision of perineal care.	4. a. Timeliness b. Written/oral reporting and recording c. Chain of command		

Unit 8F: Perineal Care

Classroom: .5
Lab: 1.0
Clinical:
Total: 1.5

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
5. Give examples of resident problems/conditions that necessitate frequent perineal care	5. a. Incontinence (urinary and fecal) b. Foley catheter c. Vaginitis		
6. Demonstrate perineal care for male and female residents	6. a. Facility policy/procedure or see Appendix A b. Perineal care as routine part of a.m. and h.s. care and more frequently as needed c. Importance of privacy and dignity during the procedure d. Use of universal precautions in providing perineal care.	Demonstration/Return Demonstration	Competence in the task will be recognized when a student performs it according to procedures for the training program

Unit 8G: Bathing - Bed/Tub/Shower

Classroom: .5
Lab: 1.0
Clinical:
Total: 1.5

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Discuss the importance of bathing	1. a. Comfort b. Hygiene c. Resident Rights d. Opportunity for communication/social interaction e. Opportunity of observations f. Integration and organization of other procedures	Class: Lecture/Discussion	Exams/Quizzes: 75% accuracy on written/oral examination
2. Describe factors which ensure the comfort, dignity, safety, cleanliness and independence of a resident who is being bathed	2. a. Knowledge, skills, attitude of staff b. Understanding of basic human needs c. Resident Rights d. Importance of nurse aide's role e. Safety factors 1) Water and environmental temperature 2) Prevention of falls f. Infection control practices		
3. Identify types of baths	3. a. Bed b. Tub c. Shower d. Whirlpool e. Other		

Unit 8G: Bathing - Bed/Tub/Shower

Classroom: .5
Lab: 1.0
Clinical:
Total: 1.5

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
4. Identify the levels of assistance that may be required for bathing	4. a. Non-assisted b. Partially assisted c. Totally assisted		
5. Identify observations the nurse aide should make while bathing a resident	5. a. Physical characteristics* b. Resident concerns* * See Units 6A through 6E (skin, hair, etc)		
6. Discuss the nurse aide's responsibility in reporting and recording observations made while bathing a resident	6. a. Timeliness b. Written/oral reporting and recording c. Chain of command		

Unit 8G: Bathing - Bed/Tub/Shower

Classroom: .5
Lab: 1.0
Clinical:
Total: 1.5

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
7. Demonstrate: a. Bed bath b. Tub bath c. Shower	7. a. Facility policy/procedure or see Appendix A b. Bed bath 1) non-assisted 2) partially assisted 3) totally assisted c. Tub bath 1) non-assisted 2) partially assisted d. Shower 1) non-assisted 2) partially assisted 3) totally assisted e. Care and storage of equipment and resident's belongings	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedures for the training program

Unit 8H: Dressing and Appearance

Classroom: .5
Lab: .5
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Identify the importance of clean, appropriate dress and appearance for the nursing home resident	1. a. Comfort b. Dignity c. Resident Rights d. Hygiene e. Social, psychological aspects of dressing and appearance	Class: Lecture/discussion	Exams/Quizzes: 75% accuracy on written/oral examinations
2. Discuss ways to promote resident rights in relation to dress and appearance	2. a. Choices b. Resident preference c. Allowing resident self care are much as possible d. Consideration of past preferences and lifestyle e. Labeling and proper care of clothing and footwear f. Consideration of resident needs in accordance with care plan		

Unit 8H: Dressing and Appearance

Classroom: .5
Lab: .5
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
3. Identify observation the nurse aide should report while dressing a resident	3. a. Missing clothing items b. Fit of clothing c. Repair needs d. Need for modification of clothes to facilitate independence e. Appropriateness for season and temperature f. Change in self care ability		
4. Demonstrate dressing a resident using the appropriate level of assistance	4. a. Facility policy/procedure or see Appendix A b. Levels of assistance 1) non-assisted 2) partially assisted 3) totally assisted b. Guidelines to ensure resident dignity 1) Undergarments 2) Resident's own clothing 3) Correctly fastened and applied clothing 4) Matching (socks, shoes, etc) 5) Appropriate coverage c. Care and storage of resident's belongings	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedures for the training program

Unit 8H: Dressing and Appearance

Classroom: .5
Lab: .5
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
5. Describe ways to enhance a resident's appearance according to resident's preference and/or past preference and lifestyle	5. a. Makeup b. Jewelry c. Nail polish d. Cologne, aftershave e. Other f. Care and storage of resident's belongings		

Unit 9: Care of the Resident Environment

Classroom: .5
Lab: 1.5
Clinical: 2.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Define resident environment	1. a. Physical 1) Temperature 2) Lighting 3) Ventilation 4) Equipment 5) Other b. Psychosocial 1) Stimulation 2) Personalization 3) Privacy c. Resident's possessions d. Relationship of environment to level of function	Class: Lecture/Discussion Guest Speaker: Resident's Council Resource: Facility Safety Committee	Exam/Quizzes: 75% accuracy on written/oral examination
2. Discuss the importance of resident's personal space	2. a. Resident Rights b. Impact on dignity, self-esteem, individualization c. Personalization of environment/resident's possessions		

Unit 9: Care of the Resident Environment

Classroom: .5
Lab: 1.5
Clinical: 2.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
3. Identify unsafe conditions in the resident's environment	3. a. Clutter b. Spills c. Equipment 1) Poor repair 2) Improper use (wheelchair, unstable chairs, restraints) d. Poor lighting e. Inappropriate temperature/humidity f. Electrical hazards g. Unclean environment h. Unsafe substances within resident's reach		
4. Identify resident risks that may result from unsafe conditions	4. a. Falls b. Hypo/hyperthermia c. Infection d. Infestation (ants, cockroaches, etc.) e. Poisoning/toxicity		

Unit 9: Care of the Resident Environment

Classroom: .5
Lab: 1.5
Clinical: 2.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
5. Describe ways the nurse aide can maintain a safe environment for the nursing home resident	5. a. Adequate lighting and temperature b. Free of clutter c. Appropriate use of: 1) Side rails 2) Call lights 3) Wheelchair brakes d. Cleanliness 1) Adherence to routine cleaning schedules 2) Evaluation of cleanliness - routine inspection e. Consideration of resident's level of function		
6. Explain the nurse aide's role in reporting and recording conditions in the resident's environment	6. A. Timeliness b. Written/oral reporting and recording c. Chain of command 1) Nursing 2) Other (maintenance, dietary, etc)		
7. Define an occupied and an unoccupied bed	7. Definition of occupied and unoccupied bed		
8. Describe the importance of handling bed linen properly	8. a. Infection control b. Dust, lint		

Unit 9: Care of the Resident Environment

Classroom: .5
Lab: 1.5
Clinical: 2.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
9. Identify situations when a resident's be linen should be changed	9. a. Soiling b. Wetness c. Resident comfort d. routine changing per facility policy		
10. Identify special equipment that may be used on the bed	10. a. Egg crate mattress b. Air mattress c. Naso-gastric tube d. Oxygen e. Urinary drainage system f. Other		
11. Demonstrate operation of the bed	11. Per facility equipment (electric, manual, etc) or see Appendix A	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedures for the training program
12. Demonstrate making an unoccupied bed	12. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	
13. Demonstrate making an occupied bed	13. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	

Unit 10: Care of the Resident with Cognitive Impairment
(Dementia - Alzheimer's Disease and Related Disorders)

Classroom: 3.0
Lab:
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Define cognitive impairment	1. Definition of cognitive impairment as diminished cognitive ability such as impaired memory, judgment, insight, capacity for logical thinking and abstract thought. Impairment of higher intellectual functions	Class: Lecture/Discussion	Exam/Quizzes: 75% accuracy on written/oral examination
2. Identify causes of cognitive impairment	2. a. Reversible causes 1) Medications 2) Malnutrition 3) Environmental 4) Dehydration 5) Other b. Irreversible causes 1) Dementia a) Alzheimer's Disease b) Multi-infarct dementia (strokes) c) Other 2) Brain injury		
3. Define dementia	3. Definition of dementia as irreversible loss of intellectual function due to a disease process		

Unit 10: Care of the Resident with Cognitive Impairment
(Dementia - Alzheimer's Disease and Related Disorders)

Classroom: 3.0
Lab:
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
4. Discuss the importance of understanding cognitive impairment and dementia and appropriate ways to care for the resident with cognitive impairment	4. a. More than half of nursing home residents have a dementing illness b. Impact of appropriate care and understanding 1) Preservation/Restoration quality of life 2) Minimal or no use of physical, chemical restraints 3) Maintenance of independence and function for as long as possible 4) Minimization of staff stress/frustration		
5. Describe the effects of cognitive impairment and implications for care	5. a. Impaired cognition/intellectual function (confusion) 1) Memory problems - especially short-term 2) Impaired judgment 3) Impaired insight 4) Impaired time orientation 5) Diminished attention span b. Altered behavior 1) Agitation 2) Combativeness 3) Nighttime wakefulness 4) Wandering 5) Delusions 6) Resistance to ADL		

Unit 10: Care of the Resident with Cognitive Impairment
(Dementia - Alzheimer's Disease and Related Disorders)

Classroom: 3.0
Lab:
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
6. Discuss common causes of increased confusion and/or altered behavior in the resident with cognitive impairment	6. a. Concept of lowered stress threshold (See attachment) b. Inability to process information (See attachment) c. Causes of increased confusion and/or altered behavior 1) Fatigue 2) Physical illness/discomfort 3) Over-stimulating environment (sensory overload) 4) New situation - change in schedule or routine 5) Medications 6) Visual/hearing impairment - distortion of information 7) Unfamiliar environment (lack of familiar cues)	Resource: See attached instructor resource sheet. Handout or reading assignment: Robinson, et al., Management of Difficult Behavior: Practical Suggestions for Coping with Alzheimer's Disease and Related Illness (1989)	

Unit 10: Care of the Resident with Cognitive Impairment
(Dementia - Alzheimer's Disease and Related Disorders)

Classroom: 3.0
Lab:
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
7. Describe ways to minimize confusion and prevent altered behavior in the resident with cognitive impairment	7. A. Communication 1) Clear 2) Slow 3) Simple, short sentences and instructions 4) Non-threatening, calm approach 5) Avoid reasoning and logic (person cannot think logically - increases frustration b. Environmental modification 1) Reduced stimulus environment 2) Familiarity/visual cues 3) Adequate lighting c. Facilitate sensory input (hearing aids, eyeglasses) d. Frequent rest periods e. Structure and routine f. Individualized care plan g. Capitalize on resident strengths/areas of intact intellect h. Techniques for encouragement/reinforcement i. Characteristics of Observations 1) Timeliness 2) Written/oral reporting and recording 3) Chain of command	Case Studies Resource: Robinson, et all, Management of Difficult Behavior	

Unit 10: Care of the Resident with Cognitive Impairment
(Dementia - Alzheimer's Disease and Related Disorders)

Classroom: 3.0
Lab:
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
8. Discuss ways to deal with the resident who is agitated, combative, or delusional	8. a. Approach person slowly from front - make eye contact b. Calm, non-threatening approach c. Take resident to quiet area with stress reduction techniques (music, massage, etc) d. Validation, refocusing techniques	Role playing Resource: See attached instructor resource sheet	
9. Describe ways to prevent and eliminate the use of physical and chemical restraints in the resident with cognitive impairment	9. a. Methods as outlined in objective 7 and 8 b. See Unit 11 on Restraints		
10. Describe ways to promote resident rights for the person with cognitive impairment	10. a. Choice based on needs and individual's capacity to make decisions b. Maintenance of function, independence, encourage and support self care c. Respect for privacy and possessions d. Treat as an adult e. See unit on Resident Rights		

Unit 10: Care of the Resident with Cognitive Impairment
(Dementia - Alzheimer's Disease and Related Disorders)

Classroom: 3.0
Lab:
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
11. Describe feelings and attitudes a nurse aide may experience in caring for a resident with cognitive impairment	11. a. Importance of knowing the resident as an individual - use resident's personal history b. Positive feelings/attitudes 1) Fondness 2) Caring, nurturing 3) Satisfaction c. Negative feelings/attitudes 1) Fear 2) Avoidance 3) Frustration 4) Impatience 5) Devaluation of the person as an individual a) Minimizing or ignoring resident's statements, feeling, etc. b) Treating the person as a child	Brief personal history - students write what they would like a nurse aide to know about them	
12. Discuss ways to use the resident's family/significant other as a source of information and support	12. a. Family/significant other as source of information 1) Resident's past preferences and lifestyle 2) Resident's personal history and interests - information to provide a view of the resident as an individual b. Family/significant other as source of support 1) Assistance with structure and routine 2) Other		

Unit 11: Creating an Environment for Restraint Elimination, Reduction, Appropriate Use

Classroom: 3.0
Lab: .5
Clinical: .5
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Identify strategies to reduce or eliminate the use of physical and chemical restraints	1. Strategies focusing on: a. Development of individualized care plans based on comprehensive assessment b. Communication c. Supervision/assistance d. Reduced stimulus environment e. Management of difficult behaviors 1) Wandering 2) Agitation/combativeness 3) Sleep disturbances 4) Hallucinations/delusions f. Falls risk reduction g. Rehabilitative/restorative care (increasing mobility, strength, activities of daily living performance) h. Meeting psychosocial needs	Class: Lecture/Discussion Handouts or Reading Assignment: Resources: Robinson, etal, Management of Difficult Behaviors Practical Suggestions for Coping with Alzheimer's Disease and Related Illnesses (1989) journal of Gerontological Nursing, 1991, 17 (2) Special issue on Restraints	Exams/Quizzes: 75% accuracy on written/oral examination

Unit 11: Creating an Environment for Restraint Elimination, Reduction, Appropriate Use

Classroom: 3.0
Lab: .5
Clinical: .5
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
2. Define physical restraint	2. Definition of physical restraint per State Operations Manual, Survey Guidelines (See attached definition)	Resources: See attached definition	
3. Identify devices in a nursing facility that could meet the definition of physical restraint	3. a. Belt b. Vest c. Wrist d. Pelvic e. Mitt f. Geri-chair g. Full side rails h. Other		
4. Give examples for the use of physical restraints a. Appropriate b. Inappropriate	4. a. a. Criteria for appropriate use of restraints b. 1) Evidence of use of less restrictive measures that proved to be ineffective 2) Temporary (ongoing evaluation with goal of using less restrictive measures) 3) Consent by resident or legal representative 4) Medically justified/medical order 5) Part of treatment plan based on comprehensive assessment		

Unit 11: Creating an Environment for Restraint Elimination, Reduction, Appropriate Use

Classroom: 3.0
Lab: .5
Clinical: .5
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
	A restraint may be used for various reasons. Differences in use are based on intent of use and whether justified, limited, supervised. For example: A vest restraint can be used to keep a resident upright in a chair; problems associated with the resident "slumping" or poor posture are greater than the problems associated with use of the device. b. Examples of appropriate use of physical restraints c. Examples of inappropriate use of physical restraints		
5. Demonstrate the application and removal of physical restraints	5. a. Importance of proper application (most injuries occur when restraints are improperly applied) b. Facility policy/procedure or see Appendix A c. Emphasis on appropriate application, removal, release, exercise every two (2) hours	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedure for the training program

Unit 11: Creating an Environment for Restraint Elimination, Reduction, Appropriate Use

Classroom: 3.0
Lab: .5
Clinical: .5
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
6. Identify appropriate observations to make while a resident is physically restrained	6. A. Effectiveness of devices in context of care plan b. Frequency of observations c. Potential problems 1) Signs of impaired circulation 2) Evidence of skin irritation/injury 3) Effects on behavior (i.e., agitation, anxiety, fear) 4) Decline in physical function or condition (mobility, incontinence, pressure sores) d. Characteristics of observations 1) Timeliness 2) Written/oral reporting and recording 3) Chain of command		
7. Define chemical restraint	7. Definition of a chemical restraint per State Operations Manual/Survey Guidelines (See attached definition)		
8. Describe the possible effects of chemical restraints	8. Changes in mood, behavior, mobility, cognition		
9. Give examples for use of chemical restraints a. Appropriate b. Inappropriate	9. A. Examples of appropriate use of chemical restraints based on individualized care plans when other strategies are ineffective b. Examples of inappropriate use of chemical restraints		

Unit 11: Creating an Environment for Restraint Elimination, Reduction, Appropriate Use

Classroom: 3.0
Lab: .5
Clinical: .5
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
10. Identify appropriate observations to be made for a resident who is chemically restrained	10. a. Effectiveness of chemical restraint in context of care plan b. Potential side effects - changes in behavior/status 1) Alteration in cognition 2) Sleepiness/lethargy 3) Impaired communication 4) Altered ability to perform activities of daily living 5) Gait disturbance 6) Dizziness c. Characteristics of observations 1) Timeliness 2) Written/oral reporting and recording 3) Chain of command		

Unit 11: Creating an Environment for Restraint Elimination, Reduction, Appropriate Use

Classroom: 3.0
Lab: .5
Clinical: .5
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
11. Discuss possible outcomes of restraint use (physical and chemical)	11. A. General - physical and psychological discomfort b. Physical 1) Increased muscle rigidity, weakness, unsteadiness - immobility, falls 2) Reduced or impaired circulation 3) Abrasions, skin tears 4) Pressure sores 5) Incontinence 6) Constipation/impaction 7) Ankylosed joints and contracted muscles 8) Bone resorption due to immobility and demineralization 9) Death - strangulation or impaired respiratory function 10) Safety to self, others 11) Maintenance/improvement of posture c. Psychological 1) Depression 2) Loss of will to live 3) Confusion 4) Change in mood and behavior (positive or negative)		

Unit 12: Vital Signs, Height, Weight

Classroom: 1.0
Lab: 1.0
Clinical: 2.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Define body temperature	1. Definition of body temperature	Class: Lecture/Discussion	Exams/Quizzes: 75% accuracy on written/oral examination
2. Identify ways of taking a resident's temperature	2. a. Routes 1) Oral 2) Rectal 3) Axillary b. Methods 1) Glass 2) Electronic thermometer 3) Topical/temp strip c. Other routes and methods per facility policy		
3. Identify normal range for body temperature	3. a. Normal range 1) Oral 2) Rectal 3) Axillary b. Fever c. Hypothermia		
4. Describe factors and conditions that affect body temperature	4. a. Infection b. Environmental temperature		

Unit 12: Vital Signs, Height, Weight

Classroom: 1.0
Lab: 1.0
Clinical: 2.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
5. Demonstrate taking and recording a resident's temperature a. Oral b. Rectal c. Axillary	5. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstrate	Competence in the task will be recognized when the student performs it according to procedures of the training program
6. Define pulse	6. Overview of cardiovascular system		
7. Identify the method used by a nurse aide to take a resident's pulse	7. a. Radial b. Other methods/sites per facility policy		
8. Identify normal range for pulse	8. Normal pulse range		
9. Describe factors/conditions that affect pulse rate	9. a. Disease 1) Infection 2) Cardio-vascular disease b. Medications c. Emotional status (stress, etc) d. Activity level		
10. Demonstrate taking and recording a resident's pulse	10. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to procedures of the training program
11. Define respiration	11. Overview of respiratory system		

Unit 12: Vital Signs, Height, Weight

Classroom: 1.0
Lab: 1.0
Clinical: 2.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
12. Identify normal range for respirations	12. Normal respiratory rate		
13. Describe factors/conditions that affect respiratory rate	13. a. Diseases 1) Infections 2) Cardio-vascular disease 3) Pulmonary disease b. Activity level		
14. Demonstrate taking and recording a resident's respiration	14. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	Competence in the task will recognized when the student performs it according to procedures of the training program
15. Define blood pressure	15. Overview of cardiovascular system		
16. Identify types of equipment for taking blood pressure	16. a. Types of sphygmomanometers b. Cuff sizes		
17. Identify factors that affect blood pressure	17. a. Diseases b. Emotional status c. Techniques and equipment d. Position e. Activity level f. Medication g. Diet (caffeine, sodium) h. Other		

Unit 12: Vital Signs, Height, Weight

Classroom: 1.0
Lab: 1.0
Clinical: 2.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
18. Demonstrate taking and recording blood pressure	Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	Competence in the task will recognized when the student performs it according to procedures of the training program
19. Describe importance of taking the resident's height and weight	19. a. Evaluation of nutritional status b. Basis for medication order c. Basis for diet orders		
20. Identify factors that affect a resident's height and weight	20. a. Aging changes b. Nutrition c. Activity level d. Diseases (osteoporosis, etc)		
21. Demonstrate taking and recording a resident's weight: a. Resident who is standing b. Resident who is unable to stand	21. a. Facility policy/procedure or see Appendix A b. Equipment 1) Balance type scale 2) Bed scale 3) Chair scale	Demonstration/Return Demonstration	Competence in the task will recognized when the student performs it according to procedures of the training program
22. Demonstrate taking and recording a resident's height: a. Resident who is standing b. Resident who is unable to stand	22. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	Competence in the task will recognized when the student performs it according to procedures of the training program

Unit 12: Vital Signs, Height, Weight

Classroom: 1.0
Lab: 1.0
Clinical: 2.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
23. Describe the nurse aide's responsibility in reporting and recording vital signs, height, and weight	23. a. Abnormal findings b. Timeliness c. Written/oral reporting and recording - flow sheets d. Chain of command		

Unit 13: Meeting Nutrition/Hydration Needs of the Nursing Home Resident
(Eating, Feeding, Hydration, I & O)

Classroom: 2.0
Lab: 1.0
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Define nutrition/hydration	1. a. Basic food groups b. Role of calories, nutrients, fluids	Class: Lecture/Discussion Guest Speaker: Dietician, County Extension Home Economist, Michigan Dairy Council Pamphlets: Michigan Dairy Council	Exams/Quizzes: 75% accuracy on written/oral examination
2. Identify nutrition/hydration needs of the nursing home resident	2. a. Nutrient/caloric requirements b. Fluid requirements c. Factors affecting nutritional needs: 1) Physical problems/diseases (diabetes, pressure sores, fever, etc) 2) Height/weight 3) Activity		
3. Identify the physical changes of aging that affect nutrition/hydration status of the nursing home resident	3. a. Taste b. Smell c. Dentition d. Thirst mechanism		

Unit 13: Meeting Nutrition/Hydration Needs of the Nursing Home Resident
(Eating, Feeding, Hydration, I & O)

Classroom: 2.0
Lab: 1.0
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
4. Describe psycho-social factors that affect nutrition/hydration status of the nursing home resident	4. a. Loneliness b. Depression c. Change in environment and routine d. Mental status (cognitive impairment)		
5. Describe changes that may occur with inadequate nutrition/hydration	5. a. Weight change b. Skin and mucous membrane changes (increased dryness) c. Lethargy d. Confusion e. Changes in elimination (constipation, oliguria_		
6. Discuss the nurse aide's responsibility in reporting/recording observations related to nutrition/hydration	6. a. Timeliness b. Written/oral reporting and recording 1) Flow sheets 2) Food acceptance record c. Accurate weight d. Chain of command		

Unit 13: Meeting Nutrition/Hydration Needs of the Nursing Home Resident
(Eating, Feeding, Hydration, I & O)

Classroom: 2.0
Lab: 1.0
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
7. Discuss the various types of special diets that may be used for a nursing home resident	7. a. Diabetic diet b. Sodium-restricted diet c. Liquid diet d. Soft diet e. Mechanical soft diet f. Nutritional supplements g. Force or restrict fluids h. Pureed i. Low cholesterol/low fat		
8. Name alternative nutrition/hydration therapies	8. a. Nasogastric tube feeding b. Hyperalimentation/Total Parenteral Nutrition (TPN) c. Intravenous (IV) d. Percutaneous Enterostomal Gastrostomy Tube (PEG Tube)		

Unit 13: Meeting Nutrition/Hydration Needs of the Nursing Home Resident
(Eating, Feeding, Hydration, I & O)

Classroom: 2.0
Lab: 1.0
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
9. Describe strategies to maintain/improve a resident's nutrition/hydration status	9. a. Resident choice/preferences b. Ethnic/cultural considerations c. Consideration of eating environment 1) Physical (noise, odors, cleanliness, etc) 2) Social (conversation, social interaction) d. Temperature and appearance of food e. Position of resident while eating f. Oral hygiene g. Dentures in place (fit) h. Handwashing for resident i. Adequate time for eating j. Timing of toileting		
10. Discuss ways to maintain/improve nutrition/hydration for the resident with special needs/problems	10. a. Methods to assist individuals with special needs: 1) Visual impairment 2) Dysphagia 3) Limited manual dexterity 4) Cognitive impairment 5) Agitation/combativeness b. Storing/hoarding food c. Non-compliance with diet	Guest Speaker: Occupational therapist Adaptive equipment utensils, plate guard, etc Resource: Medical Equipment Company	

Unit 13: Meeting Nutrition/Hydration Needs of the Nursing Home Resident
(Eating, Feeding, Hydration, I & O)

Classroom: 2.0
Lab: 1.0
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
11. Discuss the importance of a team approach in maintaining/improving a resident's nutrition/hydration status	11. Role of: a. Dietician and dietary department b. Nursing c. Social work d. Nursing Aide e. Family		
12. Demonstrate feeding techniques using the appropriate level of assistance	12. A. Facility policy/procedure or se Appendix A b. Levels of assistance 1) non-assisted 2) Partially assisted 3) Totally assisted c. Verify resident identity and appropriate tray d. Techniques for residents with special needs e. Protection of resident's clothing f. Removal of tray, food, and cleaning of eating area g. Signs indicating resident is having difficulty swallowing/choking h. Pre and post meal grooming	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedures for the training program
13. Define intake and output	13. Definition of: a. Intake (food and fluid) b. Output (feces, urine, emesis, wound drainage, perspiration)		

Unit 13: Meeting Nutrition/Hydration Needs of the Nursing Home Resident
(Eating, Feeding, Hydration, I & O)

Classroom: 2.0
Lab: 1.0
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
14. Discuss common reasons why intake and output is measured	14. Physical problems, chronic illness a. Dehydration b. Kidney failure c. Weight change d. Other		
15. Discuss the nurse aide's responsibility in reporting and recording intake and output	15. a. Timeliness b. Written/oral reporting and recording 1) Flow sheets c. Chain of command		
16. Demonstrate measuring and recording intake and output	16. A. Facility policy/procedure or see Appendix A b. Intake (food, fluids per facility policy - I.e. oz. Or cc.) c. Output 1) Urine 2) Emesis 3) Feces	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedures for the training program
17. Demonstrate the Heimlich maneuver	17. Facility policy/procedure or see Appendix A (see Unit 7 on Safety/Emergency Procedures)	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedures for the training program

Unit 14: Elimination

Classroom: 2.0
Lab: 1.0
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Identify routes of elimination	1. a. Urine b. Feces c. Skin (perspiration) d. Wound drainage e. Emesis	Class: Lecture/Discussion	Exams/Quizzes: 75% accuracy on written/oral examination
2. Describe aging changes that affect bowel and bladder elimination in the nursing home resident	2. a. Changes in bowel 1) Decreased motility, tone, sensation b. Changes in bladder 1) Decreased muscle tone, sensation 2) Decreased sphincter control		
3. Identify common elimination problems that may occur in a nursing home resident	3. a. Diarrhea b. Constipation/fecal impaction c. Urinary tract infections d. Incontinence		
4. Discuss the impact of restraint use on elimination patterns	4. a. Restraint use as a contributing factor to urinary and fecal incontinence, constipation		

Unit 14: Elimination

Classroom: 2.0
Lab: 1.0
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
5. Discuss ways to enhance elimination and prevent common elimination problems	5. a. Dietary considerations (food and fluid) b. Activity/exercise c. Frequency of toileting d. Knowledge of resident's elimination pattern e. Dignity, privacy during toileting		
6. Discuss the nurse aide's responsibility in reporting and recording observations related to elimination	6. a. Timeliness b. Verbal/oral reporting and recording c. Chain of command d. Appropriate observations to make: 1) Color 2) Odor 3) Amount 4) Character (blood, etc) 5) Frequency 6) Discomfort		
7. Discuss the nurse aide's role in bowel and bladder training	7. a. Definition of bowel and bladder training per facility procedures b. Nurse aide’s role per facility policy c. Reporting and recording		
8. Define incontinence	8. Definition of: a. Urinary incontinence b. Fecal incontinence		

Unit 14: Elimination

Classroom: 2.0
Lab: 1.0
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
9. Describe factors that may cause incontinence	9. a. Infrequent toileting b. Urinary tract infection c. Diuretics d. Laxatives e. Neurologic disorders (CVA, etc) f. Restraint use		
10. Discuss the impact of incontinence on the nursing home resident	10. a. Physical 1) Skin breakdown 2) Discomfort b. Psycho-social 1) Shame, embarrassment 2) Social isolation 3) Negative attitude of staff		
11. Discuss ways to decrease/prevent incontinent episodes	11. a. Frequent toileting b. Accessibility of toilet/commode/bedpan/urinal c. Dietary considerations d. Bowel and bladder training		
12. Identify ways to manage incontinence	12. a. Appropriate use of absorbent products/pads b. Maintenance of resident's dignity and rights		

Unit 14: Elimination

Classroom: 2.0
Lab: 1.0
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
13. Demonstrate toileting using appropriate level of assistance for: a. Toilet b. Commode c. Bedpan d. Urinal	13. a. Facility policy/procedure or see Appendix A b. Levels of assistance 1) Non-assisted 2) Partially assisted 3) Totally assisted c. Maintenance of privacy, dignity d. Universal precautions e. Care and storage of equipment	Demonstration/Return Demonstration	Competence in the task will be recognized when a student performs it according to the procedures of the training program
14. List reasons why urinary catheters are used	14. a. Intermittent vs. indwelling b. Urinary retention c. Skin breakdown d. Other		
15. Identify types of urinary catheters	15. a. Internal 1) Foley 2) Straight b. External 1) Condom drainage units c. Suprapubic catheters		

Unit 14: Elimination

Classroom: 2.0
Lab: 1.0
Clinical: 1.0
Total: 4.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
16. Discuss special considerations in caring for the resident with urinary catheter	16. a. Position of tubing b. Safety precautions when transferring or ambulating resident c. Observations to make d. Maintaining integrity of the system (patency)		
17. Demonstrate catheter care	17. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	Competence in the task will be recognized when a student performs it according to the procedures of the training program
18. Demonstrate measuring and recording output	17. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	Competence in the task will be recognized when a student performs it according to the procedures of the training program
19. Demonstrate collecting urine and stool specimens	19. Facility policy/procedure or see Appendix A a. Routine urine specimen b. Clean catch mid-stream c. Stool specimen for hemoccult d. Other	Demonstration/Return Demonstration	Competence in the task will be recognized when a student performs it according to the procedures of the training program

Unit 15: Rehabilitative/Restorative Care

Classroom: 2.0
Lab: 2.0
Clinical: 4.0
Total: 8.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Define rehabilitative/restorative care	1. Definition of rehabilitative/restorative care: a. Process by which people who have been disabled by injury or sickness are helped to recover as much as possible of their original abilities for the activities of daily living b. Activities to improve or maintain function	Class: Lecture/Discussion	Exams/Quizzes: 75% accuracy on written/oral examination
2. Identify the major goals of rehabilitative/restorative care	2. To help resident do as much as they can, as well as they can, for as long as they can * prevention * restoration * maintenance		
3. List the components of rehabilitative/restorative care	3. a. Mobility b. Range of motion c. Positioning/turning d. Transfer e. Assistive devices, i.e. wheelchair, walker		

Unit 15: Rehabilitative/Restorative Care

Classroom: 2.0
Lab: 2.0
Clinical: 4.0
Total: 8.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
4. Identify members of the rehabilitative/restorative team	4. All health care team members: a. Occupational therapist b. Physical therapist c. Speech therapist d. Restorative aide e. Nursing staff f. Social worker g. Activities Director h. Physician i. Dietician j. Family	Guest Speaker: Rehabilitative/Restorative Team Member	
5. Describe the role of the nurse aide in rehabilitative/restorative care	5. a. Maintenance of safe environment b. Psychological support i.e. encouragement, praise c. Integration of rehabilitative/restorative care plan into daily care d. Characteristics of Observations 1) Timeliness 2) Written/oral reporting and recording 3) Chain of command e. Expectation of independence		

Unit 15: Rehabilitative/Restorative Care

Classroom: 2.0
Lab: 2.0
Clinical: 4.0
Total: 8.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
6. Explain the importance of proper body mechanics for the nurse aide and resident	6. Definition of body mechanics as special ways of standing and moving one's body to make the best use of strength and avoid fatigue or injury: a. Importance for nurse aide 1) Prevention of injury (especially back injury) 2) Safety 3) Enhancement of strength and stability b. Importance for resident 1) Prevention of injury and problems (contracture) 2) Safety		
7. Demonstrate the use of proper body mechanics when delivering care	7. a. Facility policy for specific activities such as transfer, lifting, moving, etc or see Appendix A b. Incorporation of principles of body mechanics: 1) Broadened stance/wide base of support 2) Use of major muscle groups for lifting 3) Appropriate posture/body alignment	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedures for the training program

Unit 15: Rehabilitative/Restorative Care

Classroom: 2.0
Lab: 2.0
Clinical: 4.0
Total: 8.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
8. Describe the importance of maintaining a resident's mobility	8. Definition of mobility as ambulation and maintenance of joint function a. Prevention of problems related to immobility 1) Cardio-vascular deconditioning 2) Loss of muscle tone/strength 3) Pressure sores 4) Contractures 5) Constipation 6) Psychological effects 7) Joint stiffness "disuse syndrome" 8) Hypostatic pneumonia b. Benefits of maintaining mobility 1) Maintenance of physical function 2) Maintenance of psychological function		
9. Demonstrate proper ambulation	9. Facility policy/procedure or see Appendix A a. Ambulation without assistance b. Ambulation with assistance c. Ambulation with walker d. Ambulation with cane e. Use of wheelchair f. Use of artificial limb	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedures for the training program
10. Demonstrate transfer technique	10. Facility policy/procedure or see Appendix A a. Transfer to and from: chair, bed, wheelchair, commode, toilet, other b. Equipment: mechanical lifts, slide boards, transfer belt	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedures for the training program

Unit 15: Rehabilitative/Restorative Care

Classroom: 2.0
Lab: 2.0
Clinical: 4.0
Total: 8.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
	c. Other		
11. Describe the benefits of proper turning and positioning	11. Prevent/minimize: a. Pressure sores b. Contractures c. Joint stiffness d. Discomfort/pain		
12. Discuss factors that determine the frequency of positioning/turning a resident	12. a. Resident's request b. Physician order c. Care Plan		
13. Demonstrate technique for positioning/turning a resident	13. Facility policy/procedure or see Appendix A for positioning/turning: a. Turning in bed b. Positioning in bed c. Positioning in chair	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedures for the training program
14. Discuss the nurse aide's responsibility in reporting, recording and observing related to positioning/turning of resident	14. a. Timeliness b. Written/oral reporting c. Chain of command		
15. Demonstrate proper use of equipment for positioning/turning	15. Facility policy/procedure or see Appendix A regarding: sandbags, pillows, etd	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedures for the training program

Unit 15: Rehabilitative/Restorative Care

Classroom: 2.0
Lab: 2.0
Clinical: 4.0
Total: 8.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
16. Identify the importance of range of motion exercises for nursing home residents	16. a. Exercise muscles and joints b. Maintenance of mobility and function		
17. Demonstrate active and passive range of motion	15. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedures for the training program
18. Identify reasons for using Assistive devices	18. Maintenance of mobility, function and independence, improvement in function	Guest Speaker: Occupational therapist with demonstration of use of Assistive devices	
19. Give example of Assistive devices	19. Eating aids, plate guards, braces, splints and prosthetic devices		

Unit 16: Care of the Resident with Mental Retardation (Developmental Disability)

Classroom: 1.0
Lab:
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Discuss characteristics of the resident with mental retardation (developmental disabilities)	1. a. Cognitive/intellectual characteristics 1) Impaired memory 2) Impaired ability to learn 3) Decreased attention span 4) Poor impulse control 5) Impaired language/communication 6) May have limited ability to perform ADL's independently b. Psychological characteristics 1) Altered perceptions 2) Emotional liability 3) Inappropriate responses c. Chronological age will not match developmental age	Class: Lecture/Discussion	Exams/Quizzes: 75% accuracy on written/oral examination
2. Identify the common causes of mental retardation (developmental disability)	2. a. Congenital disorders (ie. Down's Syndrome) b. Brain injury		

Unit 16: Care of the Resident with Mental Retardation (Developmental Disability)

Classroom: 1.0
Lab:
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
3. Describe the nurse aide's role in caring for the resident with mental retardation (developmental disabilities)	3. A. Maintenance of resident rights and dignity b. Physical needs 1) Safety 2) Supervision (ADL, activities) c. Psychological needs 1) Communication methods 2) Acceptance and support 3) Encouragement for self-help and independence 4) Assist other residents to be sensitive to the needs of the person with mental retardation		

Unit 17 Depression

Classroom: 1.0
Lab:
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Identify symptoms of depression in the elderly	1. a. Sadness b. Withdrawal c. Fatigue d. Anorexia e. Weight loss f. Sleep disturbance g. Confusion h. Suicidal thoughts	Class: Lecture/Discussion Guest Speaker: Mental Health Professional Social Worker Physician Pharmacist	Exams/Quizzes: 75% accuracy on written/oral examination
2. Name two types/causes of depression in the elderly	2. a. Situational 1) Losses 2) Nursing home placement b. Chemical 1) Medication side effects 2) Altered brain chemicals (neurotransmitters)		
3. Identify possible outcomes of untreated depression	3. a. Suicide 1) Active 2) Passive (refusing meds, food) b. Increasing physical debilitation due to weight loss, etc.		

Unit 17 Depression

Classroom: 1.0
Lab:
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
4. Identify methods used to treat depression	4. a. Counseling b. Medication		
5. Discuss the nurse aide's role in caring for a resident who is depressed	5. a. Observation and reporting of symptoms/behavior change b. Reassurance, support - convey individual's value and worth c. Listening d. Encouragement/participation in activities and socialization as appropriate		

Unit 18: Death and Dying

Classroom: .5
Lab: .5
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Describe common feelings that a nursing home resident may have about death and dying	1. a. Acceptance (may be a common response in nursing home residents) b. Fear c. Denial d. Anger	Class: Lecture/Discussion Guest Speaker: Social Worker/Mental Health Professional Physician Pharmacologist	Exams/Quizzes: 75% accuracy on written/oral examination
2. Identify physical needs of the dying resident	2. a. Comfort/positioning b. Environment c. Hygiene/cleanliness		
3. Identify psychological needs of the dying resident	3. a. Dignity b. Resident preference regarding solitude or interaction c. Support/understanding d. Need for listening and touch e. Awareness of resident's sensitivity to what is being said/ability to hear when other senses diminished f. Spiritual needs		

Unit 18: Death and Dying

Classroom: .5
Lab: .5
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
4. Describe the feelings and responses the resident's family, friends, roommate may have during the dying process	4. a. Guilt b. Anger c. Sadness/depression d. Avoidance e. Denial f. Acceptance g. Relief		
5. Describe the nurse aide's role in caring for a dying resident	5. a. Physical care/comfort b. Support and caring c. Observations d. Reporting/recording appropriate information e. Knowledge of nursing care plan regarding advanced directives		
6. Describe the nurse aide's role in working with the family of a dying resident	6. a. Interaction and communication of appropriate information per facility policy b. Reporting/recording - appropriate information c. Understanding/support d. Comfort (information about meals, coffee, etc) e. Special visiting policy		

Unit 18: Death and Dying

Classroom: .5
Lab: .5
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
7. Identify ways to support other nursing home residents when a resident dies	7. a. Listening b. Caring, interested attitude c. Appropriate observations (signs of depression, etc) d. Reporting/recording appropriate information		
8. Identify one's own feelings about death/dying	8. a. Self-examination of feelings (loss, sadness, etc) Nurse aide's relationship with resident	Small group discussion or short written b. assignment Guest Speaker: Funeral Director Pastoral Care Counselor	
9. Describe ways to cope with one's own feelings when a resident dies	9. a. Talking with peers b. Talking with professional staff c. Other	Case study using an actual resident	
10. Demonstrate post-mortem care	10. Facility policy/procedure or see Appendix A	Demonstration/Return Demonstration	Competence in the task will be recognized when the student performs it according to the procedures of the training program

Unit 19: The Resident with Acquired Immune Deficiency Syndrome (AIDS)

Classroom: 1.0
Lab:
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Define Acquired Immune Deficiency Syndrome	1. Definition of Acquired Immune Deficiency Syndrome	Class: Lecture/Discussion Resources: State Health Department - Office of AIDS Prevention Local Health Department American Red Cross American Health Care Association - The Nursing Home Resident with AIDS	Exams/Quizzes: 75% accuracy on written/oral examination
2. Define Human Immunodeficiency Virus (HIV)	2. Definition of HIV		

Unit 19: The Resident with Acquired Immune Deficiency Syndrome (AIDS)

Classroom: 1.0
Lab:
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
3. Identify sources of the AIDS virus (HIV) and methods of transmission	3. a. Sources of HIV 1) HIV positive blood 2) HIV positive body fluids b. Methods of transmission of HIV - Direct contact of blood with HIV positive blood, body fluids 1) Transfusions 2) Puncture wounds/needle sticks/breaks in skin 3) Mucous membranes "splashed" with contaminated body fluids 4) Sexual contact		
4. Describe symptoms and problems of the nursing home resident with AIDS	4. a. Physical 1) Physical debilitation 2) Susceptibility to infection 3) Cognitive impairment (dementia syndrome) b. Psychological 1) Age (younger than typical nursing home resident) 2) Depression 3) Fear 4) Guilt 5) Death, dying issues		
5. Discuss one's own feeling and attitudes about caring for the resident with AIDS	5. Self-examination of feelings b. Importance of accurate knowledge	a. Group discussion Written assignment	

Unit 19: The Resident with Acquired Immune Deficiency Syndrome (AIDS)

Classroom: 1.0
Lab:
Clinical:
Total: 1.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
6. Describe the nurse aide's role in caring for the resident with AIDS	6. a. Resident rights/confidentiality b. Physical needs 1) Comfort 2) Hygiene 3) Use of Universal Precautions - see Unit 6 4) Nutrition c. Psychological needs 1) Support 2) Listening 3) Maintenance of dignity d. Reporting/recording appropriate information		

Unit 20: Clinical Practicum

Classroom:
Lab:
Clinical: 7.0
Total: 7.0

LEARNER OBJECTIVES	CONTENT	METHODOLOGIES	EVALUATION
UPON COMPLETION OF THIS UNIT THE STUDENT WILL BE ABLE TO:			
1. Demonstrate beginning ability to function as a nurse aide in a long term care facility	1. Resident care which integrates knowledge and skills of nurse aide	Observation, supervision and evaluation of trainee by the Primary Instructor (PI) or Delegated Instructor (DI) * * DI must be supervised by PI	